

CERTIFICATE OF DEATH

Reg. Dist. No.

Feb. 1, 1958

1. NAME OF DECEASED  
(Type or Print)

JOANNE IRENE ABRAHMS

2. DATE  
OF  
DEATH

3. PLACE OF DEATH:

A. Baltimore City, Maryland Baltimore County

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

STATE Md. COUNTY Baltimore

B. FULL NAME OF (If not in hospital or institution, give street address or location)  
HOSPITAL OR INSTITUTION

634 Plymouth Rd.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Balto. - 29 X

D. STREET ADDRESS (If rural, give location)

634 Plymouth Rd.

c. Length of stay in Baltimore

5. SEX

female

6. COLOR OR RACE

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)

single

8. DATE OF BIRTH

Mar. 22, 1945

9. AGE (In years last birthday)

12

10. Under 1 Year Months: Days

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

John Edward Abrahms

14. MOTHER'S MAIDEN NAME

Iney Doris Marling

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT

Mr. John Edw. Abrahms - 634 Plymouth Rd.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A)

Cardiovascular Collapse 2 days

DUE TO

ANTECEDENT CAUSES

(B)

Unbecile Congenital

DUE TO

(C)

Absence of other operative factors 12 yrs

INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20. AUTOPSY?

YES ☐ NO ☒

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED

m.

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Sept 1, 1945 to 1945, that (I) (we) last saw the deceased alive on 1945, and that death occurred at 1 P.M., from the causes and on the date stated above.

23A. SIGNATURE

23B. ADDRESS

23C. DATE SIGNED

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

M.D.

24A. BURIAL, CREMATION, REMOVAL (Specify)

Burial

24B. DATE

2/5/58

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cem.

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

DATE RECEIVED BY LOCAL REGISTRY

FEB 3 - 1958

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR

ADDRESS

Mr. J. L. Dickner & Sons

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



TO: DIRECTOR, FBI (100-371711)  
FROM: SAC, NEW YORK (100-100000)  
SUBJECT: [REDACTED]  
RE: [REDACTED]

[The body of the letter contains several paragraphs of text that are mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some legible fragments include:]

...the following information was obtained from the New York office of the Federal Bureau of Investigation...

...on February 6, 1958, the New York office advised that...

...the New York office is currently conducting an investigation...

...the New York office is currently conducting an investigation...

...the New York office is currently conducting an investigation...

BUREAU FILE

FEB 6 1958

RECEIVED

1560

CERTIFICATE OF DEATH

01527

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balt.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN TB <u>3 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PARADISE NURS. HOME</u> <u>PARADISE &amp; ALAMONT AVE</u>				d. STREET ADDRESS <u>16318 MT. RIDGE RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>A.</u> Last <u>ACKERMAN.</u>				4. DATE OF DEATH Month <u>FEB.</u> Day <u>25</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR. 13, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STORE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CONRAD ACKERMAN</u>				14. MOTHER'S MAIDEN NAME <u>ANNA - - -</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>21334-9905</u>		17. INFORMANT <u>MRS. HOWARD DURHAM</u> <u>6318 MT. RIDGE RD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>arteriosclerotic cardiovascular disease with markedly impaired circulation, left lower leg and gangrene of Rt. 4th &amp; 5th toes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO <u>  </u> (c) DUE TO <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr +</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-25-58</u> , 19 <u>  </u> , to <u>2-25-58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>2-24-58</u> , 19 <u>  </u> , and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1118 St Paul St. Baltimore, 2, Md</u> DATE SIGNED <u>2-26-58</u>							
ACTUAL SIGNATURE <u>John A. Nesbitt Jr</u>		M.D. <u>  </u>					
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR</u>		<u>Baltimore, 2, Md</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITZKE FUNERAL DIRECTORS</u> <u>5101 EDMONDSON AVE.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 28 1958</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 28 1953

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1561

## CERTIFICATE OF DEATH

01528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>1mth1lds</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01-4</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS <u>105 S. Monastery Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Julia</u> Middle <u>Ann</u> Last <u>Akers</u>				4. DATE OF DEATH Month <u>February</u> Day <u>6</u> Year <u>1958</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29, 1875</u>	
9. AGE (In years lost birthday) yrs. <u>82</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>John McCarthy</u>			
14. MOTHER'S MAIDEN NAME <u>Ellen Custy</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>213-12-8666</u>				17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 24</u> , 19 <u>57</u> , to <u>Feb. 6</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 6</u> , 19 <u>58</u> , and that death occurred at <u>3:50a</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachsler</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 2-6-58</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachsler, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-10-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral CEM</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. Duman Schwab</u>				ADDRESS <u>3512 Frederick Ave. (29)</u>		24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Wachsler</u>							

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

RECEIVED

BUREAU V. S.

FEB 10 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

01529

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth26dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Samuel J. Alascia</b>		4. DATE OF DEATH Month Day Year <b>February 27 19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1897</b>
9a. AGE (In years last birthday) yrs. <b>60</b>		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GRAVEL CO</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown SALVATORE A. ALASCIA</b>		14. MOTHER'S MAIDEN NAME <b>Unknown GIOVANNA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown W.W.I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Nephrosclerosis</b> (c) <b>Arteriosclerosis, genl. and severe</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 31</b> , 19 <b>57</b> , to <b>Feb. 27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 27</b> , 19 <b>58</b> , and that death occurred at <b>11:40a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>SPRING GROVE STATE HOSPITAL 2-27-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>3-3-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CATHEDRAL CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Forley Funeral Home - Catonsville, Md.</b>		ADDRESS <b>24a. REC'D BY REGISTRAR DATE MAR 3 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>			

CERTIFICATE OF DEATH

Case No. 100-10000

100-10000

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. 3

MAR 3 1958

RECEIVED

## CERTIFICATE OF DEATH

01530

Reg. Dist. No.

1563

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Conowingo, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Private home</u>		d. STREET ADDRESS <u>07X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Malon</u> Middle <u>Pusey</u> Last <u>Alexander</u>		4. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 29, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Conowingo, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Chromas Alexander</u>		14. MOTHER'S MAIDEN NAME <u>Mary Founds</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>180-094588</u>	
17. INFORMANT <u>Molly Cauldell-Alexander</u>		Address <u>Conowingo Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>2/5</u> , 19 <u>58</u> , to <u>2/11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/11/58</u> , 19 <u>58</u> and that death occurred at <u>8:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Neil R Taylor</u> M.D.		ADDRESS (Street, city or town, state) <u>Rising Sun, Md</u> DATE SIGNED <u>2/13/58</u>	
PHYSICIAN'S NAME (Type) <u>Neil R Taylor</u>		<u>Rising Sun, Md</u> <u>2/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-14-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Conowingo, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman E. McMillen</u>		ADDRESS <u>Rising Sun Md</u>	
24a. REC'D BY REGISTRAR <u>FEB 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

File No. 100

BUREAU V. 2

FEB 14 1958

RECEIVED



## 01531

00

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>19-</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>as</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		c. LENGTH OF STAY IN lb <u>14 months</u> x <u>m</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2112 Alma Ave.</u>		d. STREET ADDRESS <u>#1</u>	
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>JANE</u> Middle <u>ALLMOND</u> Last		4. DATE OF DEATH <u>Feb. 17</u> Month <u>19</u> Day <u>58</u> Year	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. SA.</u>	
13. FATHER'S NAME <u>Charles Storrs</u>		14. MOTHER'S MAIDEN NAME <u>Ella Allmond</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Minnie McBloune</u>		Address <u>as in #1</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lobar pneumonia</u> DUE TO (c) <u>arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>3 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>490x</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 29</u> , 19 <u>51</u> , to <u>Feb 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 16</u> , 19 <u>58</u> , and that death occurred at <u>6 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Tollin</u>		DATE SIGNED <u>2/17/58</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS N. TOLLIN</u>		<u>Balto. 19-Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>2-20-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. P. ...</u>		ADDRESS <u>Dundalk, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>...</u>	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES ALMOND		35		M		W		1903		NEW YORK		NEW YORK		NEW YORK		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
FEB 24 1938		NEW YORK		NEW YORK		NEW YORK		NEW YORK		FEB 24 1938		NEW YORK		NEW YORK		NEW YORK	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		ANGINA PECTORIS		HYPERTENSION		FEB 24 1938		NEW YORK		NEW YORK		NEW YORK	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAMES ALMOND		JAMES ALMOND		JAMES ALMOND		JAMES ALMOND		JAMES ALMOND		FEB 24 1938		NEW YORK		NEW YORK		NEW YORK	

BURKAU V. S.

FEB 24 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1532 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01532

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>BALTIMORE</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			c. LENGTH OF STAY IN 1b <b>9 Mos.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> <span style="float: right;">53</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2526 McComas Avenue</b>				d. STREET ADDRESS <b>2526 McComas Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MARY C.</b> Middle <b>ARRINGTON</b> Last				<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>10</b> Year <b>1958</b>			
<b>5. SEX</b> <b>F.</b>	<b>6. COLOR OR RACE</b> <b>W.</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>OCT. 19, 1891</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>BALTIMORE MD.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>GOSNELL</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		<b>17. INFORMANT</b> <b>3670 Kenyon Avenue Balto. 13.</b> <b>MR. CHARLES J. ARRINGTON</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Obesity</b> <b>Varicose Veins</b> <b>Boils</b>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <b>MB Davis</b>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <b>MB DAVIS M.D.</b>				<b>DATE SIGNED</b> <b>2/11/58</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>2/14/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Baltimore Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>HENRY SANDER &amp; SONS INC. BALTO. MD.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE FEB 13 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

FEB 13 1958

BUREAU V. S.

1565

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>18 W. Pennsylvania Avenue</b>				d. STREET ADDRESS <b>18 W. Pennsylvania Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LETITIA C. ASCHERFELD</b>				4. DATE OF DEATH Month Day Year <b>February 19, 1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1867</b>		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William J. Cousins</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Ross Small</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Daisy E. Ascherfeld, 18 W. Penna. Ave., Towson</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>450.0</b> DUE TO <b>Arteriosclerosis, generalized</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 3</b> , 19 <b>58</b> , to <b>FEB 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>FEB 10</b> , 19 <b>58</b> , and that death occurred at <b>5:20 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>T. C. Siwinski</b>		M.D. <b>17 W. Penna. Ave</b>		ADDRESS (Street, city or town, state)		DATE SIGNED <b>2/20/58</b>	
PHYSICIAN'S NAME (Type) <b>T. C. SIWINSKI</b>		<b>Towson, 4 Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 58</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the required information prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

4865

185-500-100

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH JAN 15 1968	
PLACE OF DEATH BALTIMORE, MARYLAND		AGE 35	
OCCUPATION FARMER		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. H. SMITH	
DATE OF BURIAL JAN 18 1968		PLACE OF BURIAL GREENWOOD CEMETERY	
NAME OF FUNERAL HOME JOHN J. SMITH		NAME OF NEXT OF KIN JAMES EARL RAY	
ADDRESS OF NEXT OF KIN 1234 MAIN ST, BALTIMORE, MD		DATE OF DEATH JAN 15 1968	
NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH JAN 15 1968	
PLACE OF DEATH BALTIMORE, MARYLAND		AGE 35	
OCCUPATION FARMER		CAUSE OF DEATH HEART DISEASE	
MANNER OF DEATH NATURAL		SIGNATURE OF PHYSICIAN J. H. SMITH	
DATE OF BURIAL JAN 18 1968		PLACE OF BURIAL GREENWOOD CEMETERY	
NAME OF FUNERAL HOME JOHN J. SMITH		NAME OF NEXT OF KIN JAMES EARL RAY	
ADDRESS OF NEXT OF KIN 1234 MAIN ST, BALTIMORE, MD		DATE OF DEATH JAN 15 1968	

BUREAU V. S.

FEB 24 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film G225 1542 2/10/58 GTE

## CERTIFICATE OF DEATH

Reg. Dist. No.

01535

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe, Md.</b>		c. LENGTH OF STAY IN 1b <b>29 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1233 Oakland Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>G.</b> Last <b>Bailey</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>1958.</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1903</b> <b>Jan. 14-1903</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Lulu Metz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-01-4249</b>	
17. INFORMANT <b>Ethel Bailey</b>		Address <b>1233 Oakland Terrace.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> <b>154X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Adenocarcinoma of recto-sigmoid</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>18 mo.</b> <b>2 1/2 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December</b> , 19 <b>56</b> , to <b>Feb. 2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan. 26</b> , 19 <b>58</b> , and that death occurred at <b>4 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10 W. Madison St., Baltimore, Md.</b> DATE SIGNED <b>2-4-58</b>			
ACTUAL SIGNATURE <b>Paul G. Herold</b>		M.D. <b>10 W. Madison St., Baltimore, Md.</b> <b>2-4-58</b>	
PHYSICIAN'S NAME (Type) <b>Paul G. Herold, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6-58.</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cema</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Seaside Repty</b>		ADDRESS <b>5646 Carville Ave.</b>	
24a. REC'D BY REGISTRAR <b>FEB 6 58</b>		DATE <b>Feb 6 58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

CERTIFICATE OF DEATH

DECEASED		DATE OF DEATH	
PLACE OF DEATH		CITY	
COUNTY		STATE	
AGE		SEX	
MARRIAGE		OCCUPATION	
EDUCATION		RELIGION	
CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

FEB 6 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1566

## CERTIFICATE OF DEATH

01536

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Baltimore</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Adela</b> Middle <b>M.</b> Last <b>Baker</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 26, 1875</b>	
9. AGE (In years lost birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Melker T. Buell</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Thompson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>unknown</b>			
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO <b>Arteriosclerosis, generalized and severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized and severe</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan. 21, 1958</b> , to <b>Feb. 3, 1958</b> , that I last saw the deceased alive on <b>Feb. 3, 1958</b> , and that death occurred at <b>7:30 p. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Augusto J. Esquibel</b>				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-3-58</b>			
PHYSICIAN'S NAME (Type) <b>Augusto J. Esquibel, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Middletown Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Middletown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home</b>				ADDRESS <b>2112 Dundalk Ave.</b>			
24a. REC'D BY REGISTRAR <b>FEB 7 1958</b>				24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

534

BUREAU V. 3

FEB 7 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01537

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1567

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hydes Md</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hydes Md.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Rd.</b>				d. STREET ADDRESS <b>Harford Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RANDOLPH EVANS BALL</b>			4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 58</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 1-1941</b>		9. AGE (In years last birthday) <b>17</b> yrs.	IF UNDER 1 YEAR Months <b>17</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min. <b>17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trash Collector</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trash Removal</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert R BALL</b>			14. MOTHER'S MAIDEN NAME <b>Mildred Burton</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-38-6419</b>		17. INFORMANT <b>Robert R Ball</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive peritoneal hemorrhage due to Crushing Injury of Abdomen</b> Conditions, if any, which gave rise to immediate cause (b) <b>819X</b> (a), stating the underlying cause last. (c) <b>DUE TO</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Auto struck bridge abutment</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto struck bridge abutment</b>				
20c. TIME OF INJURY Month, Day, Year <b>11:15 p.m. 2/26/ 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Hartley Mill Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>			M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			22b. DATE THEREOF <b>3-1-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fork Methodist</b>		22d. LOCATION (city, town, or county) (State) <b>Fork Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas F. Evans &amp; Son</b>				ADDRESS <b>8802 Harford Rd</b>		24a. REC'D BY REGISTRAR <b>MAR 4 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Alvin Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
JUN 27 1958  
BUREAU V. S.

*[Faint handwritten notes at the bottom of the page]*



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>60 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>2309 Ashland Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>L.</b> Last <b>BANTON</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/17/78</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel setter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U/S.A.</b>	
13. FATHER'S NAME <b>George Banton</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Sargent</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes SA W &amp; W I.</b>		16. SOCIAL SECURITY NO. <b>219-26-6838</b>	
17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF HEAD OF PANCREAS WITH METASTASIS TO LIVER AND ABDOMINAL LYMPH NODES</b> (b) <b>GENERALIZED PERITONITIS</b> DUE TO (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN UNKNOWN</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>December 9, 1957</b> , to <b>February 7, 1958</b> , and that death occurred at <b>5:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chien Wei Jan</b>		ADDRESS (Street, city or town, state) <b>VAH FORT HOWARD, MD.</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI JAN, M. D.</b>		DATE SIGNED <b>2/8/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/11/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sam J. Banton - Secy of</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Sander</b>

H.SANDER &amp; SONS, INC. NORTH AVE. AND BROADWAY, BALTO., MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 5.6.7 Film G226 2-28-58 et

## CERTIFICATE OF DEATH

01539

Reg. Dist. No.

1569

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eatonville</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Ruess</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Barry</u> First <u>Mary</u> Middle Last				4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-23-1883</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel</u>				14. MOTHER'S MAIDEN NAME <u>Leah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Samuel Flow</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decomensation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Hypertensive Cardio-Vascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>17 mo</u> <u>1031</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>9-26</u> , 19 <u>57</u> , to <u>2-23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-23</u> , 19 <u>58</u> , and that death occurred at <u>8:10 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u> M.D.				ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore-25, Md.</u>			
DATE SIGNED <u>2-24-58</u>							
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis</u> ADDRESS <u>2100 Ecton Pl</u>				24a. REC'D BY REGISTRAR <u>FEB 25 1958</u>		24b. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100-1

BUREAU V.S.S.

FEB 25 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01540

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">1570</span> <div style="text-align: center; font-size: 1.2em;">Baltimore</div> <div style="text-align: right; font-size: 0.8em;">MARYLAND</div>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Md.</span> b. COUNTY <span style="font-size: 1.2em;">Baltimore</span>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <div style="text-align: center; font-size: 1.2em;">Reisterstown</div>		c. LENGTH OF STAY IN 1b <div style="text-align: center; font-size: 1.2em;">X Reisterstown</div>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <div style="text-align: center; font-size: 1.2em;">Baublitz Road</div>		d. STREET ADDRESS <div style="text-align: center; font-size: 1.2em;">Baublitz Road</div>	
<b>3. NAME OF DECEASED</b> (Type or print)      First      Middle      Last <div style="text-align: center; font-size: 1.2em;">Benjamin      H.      Baublitz</div>		<b>4. DATE OF DEATH</b> <div style="text-align: center; font-size: 1.2em;">Feb. 17, 1958</div>	
<b>5. SEX</b> <div style="text-align: center; font-size: 1.2em;">Male</div>	<b>6. COLOR OR RACE</b> <div style="text-align: center; font-size: 1.2em;">White</div>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <div style="text-align: center; font-size: 1.2em;">Dec. 11, 1888</div>
<b>9. AGE</b> (In years and birthday) <div style="text-align: center; font-size: 1.2em;">69 yrs.</div>		<b>IF UNDER 1 YEAR</b> Months      Days      Hours      Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="text-align: center; font-size: 1.2em;">Farmer, self employed</div>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <div style="text-align: center; font-size: 1.2em;">Maryland</div>	
<b>11. BIRTHPLACE</b> (State or foreign country) <div style="text-align: center; font-size: 1.2em;">U.S.</div>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="text-align: center; font-size: 1.2em;">U.S.</div>	
<b>13. FATHER'S NAME</b> <div style="text-align: center; font-size: 1.2em;">Jermiah Baublitz</div>		<b>14. MOTHER'S MAIDEN NAME</b> <div style="text-align: center; font-size: 1.2em;">Mary Jane Frank</div>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)      (If yes, give war or dates of service) <div style="text-align: center; font-size: 1.2em;">no</div>		<b>16. SOCIAL SECURITY NO.</b> <div style="text-align: center; font-size: 1.2em;">none</div>	
<b>17. INFORMANT</b> <div style="text-align: center; font-size: 1.2em;">Mrs. Thomas Parker, Swings Mills, Md.</div>		<b>Address</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Coronary Artery Disease</span>  <div style="margin-top: 10px;"> <b>420.1</b> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.      (b)      (c)         </div> </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <div style="font-size: 1.2em;">2 mos.</div> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <div style="text-align: center; font-size: 1.2em;">Carcinoma of colon with resection 1947 Hernia - 10 yrs.</div>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <div style="text-align: center; font-size: 1.2em;">none      none</div>	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <div style="text-align: center; font-size: 1.2em;">none</div>		<b>20c. TIME OF INJURY</b> Month, Day, Year Hour      a. m.      p. m. <div style="text-align: center; font-size: 1.2em;">none      19</div>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <div style="text-align: center; font-size: 1.2em;">none</div>	
<b>20f. (City or town)</b> <div style="text-align: center; font-size: 1.2em;">none</div>		<b>(County)</b> <b>(State)</b>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> ,      Accident <input type="checkbox"/> ,      Suicide <input type="checkbox"/> ,      Homicide <input type="checkbox"/> ,      Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">D. D. Caples</span>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">D. D. Caples, M. D.</span>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <div style="text-align: center; font-size: 1.2em;">2-20-58</div>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <div style="text-align: center; font-size: 1.2em;">Burial</div>		<b>22b. DATE THEREOF</b> <div style="text-align: center; font-size: 1.2em;">Feb. 20, 1958</div>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <div style="text-align: center; font-size: 1.2em;">Grace Cemetery</div>		<b>22d. LOCATION (City, town, or county)</b> <b>(State)</b> <div style="text-align: center; font-size: 1.2em;">Falls Road, Baltimore Co. Md.</div>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <div style="text-align: center; font-size: 1.2em;">J.F. Eline &amp; Sons, Reisterstown, Md.</div>		<b>24a. REC'D BY REGISTRAR</b> <div style="text-align: center; font-size: 1.2em;">FEB 24 '58</div>	
<b>24b. REGISTRAR'S SIGNATURE</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your use.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



IRLAND STATE DEPARTMENT OF HEALTH - BUREAU 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

FEB. 24 1958

RECEIVED





RECEIVED

FEB 11 1959

BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01542

Reg. Dist. No.

1572

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b> c. LENGTH OF STAY IN 1b <b>33 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>4403 Colfax Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JESSE</b> Middle <b>G.</b> Last <b>BLANCHARD</b>		4. DATE OF DEATH Month <b>2</b> Day <b>21</b> Year <b>1958</b>				
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-98</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AUTO-MECHANIC</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>JAMES MONROE BLANCHARD</b>			14. MOTHER'S MAIDEN NAME <b>HARRIET STRICKLAND</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW #1 577-09-6300</b>		17. INFORMANT Address <b>Hospital records, Mt. Wilson State Hospital</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA of the LUNG</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA of the LIVER</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PULMONARY TUBERCULOSIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>2 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>1-17</b> , 19 <b>58</b> , to <b>2-21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-21</b> , 19 <b>58</b> , and that death occurred at <b>3 A.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b> Superintendent						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>MONTGOMERY COUNTY, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Watner E. Pumphrey</b> ADDRESS <b>Silver Spring, Md.</b>				24a. REC'D BY REGISTRAR <b>Feb 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Deedman</b>

**BUREAU V. 3**

FEB 26 1968

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TO HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VS A15 (4)  
15M 10/57

1543

1543

01543

Reg. Dist. No.

1. PLACE OF DEATH  
o. COUNTY Baltimore MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
o. STATE MD. b. COUNTY Baltimore

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b  
Halethorpe 51 Halethorpe

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1402 Avon Court e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

4. DATE OF DEATH 2-18-58 19

3. NAME OF DECEASED (Type or print) First Middle Last John William Blankenheim

5. SEX Male 6. COLOR OR RACE white 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH Aug. 4, 1897 9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?  
Hauling Business Self Baltimore U.S.

13. FATHER'S NAME William Blankenheim 14. MOTHER'S MAIDEN NAME Anna M. EXX Streit

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO none 17. INFORMANT Address Irene M. Blankenheim 1402 Avon Court

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 177X Carcinoma of Prostate 2 yrs  
DUE TO 5 metastasis 1 yr  
(b) Rt Hemiplegia (Paralysis) 1 day  
DUE TO arterial Hypertension 6 mo  
(c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While ☐ Not while ☐ of work ☐ of work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 1957, to Feb 18 1958, that I last saw the deceased alive on Feb 13 1958, and that death occurred at 4 P. M, from the causes and on the date stated above.  
ADDRESS (Street, city or town, state) DATE SIGNED  
ACTUAL SIGNATURE B B Brumbaugh M.D. 5609 Main St 4/21/58  
PHYSICIAN'S NAME (Type) B B Brumbaugh Elbridge 27 st

22a. BURIAL, CREMATION, (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State)  
Burial 2-22-58 Loudon Park Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE  
Howard H. Hubbard 4107 Wilkens Ave. DATE FEB 24 '58



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BUREAU V. S.

FEB 24 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the office prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01544

1573

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Pines</u>		d. STREET ADDRESS <u>5731 Jonquill Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Rose</u> Middle <u>Blatt</u> Last		4. DATE OF DEATH Month <u>2-</u> Day <u>7-</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Meyer</u>		14. MOTHER'S MAIDEN NAME <u>Hettie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT Address <u>Nathan Weinstein - same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRO-VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X 1) DIABETES MELLITUS 2) PREVIOUS CVA, MULTIPLE</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>JULY</u> , 19 <u>57</u> , to <u>FEB. 7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB. 6</u> , 19 <u>58</u> , and that death occurred at <u>12:45 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Marvin Goldstein</u> M.D. <u>5334 LIBERTY HEIGHTS AVE.</u> PHYSICIAN'S NAME (Type) <u>BALTO. 7, MD.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u> 22b. DATE THEREOF <u>2-9-58</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Toledo Ohio</u> 22d. LOCATION (City, town, or county) (State) 23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewin</u> ADDRESS <u>2100 Eutaw Pl</u> 24a. REC'D BY REGISTRAR DATE <u>FEB 11 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Dr. Lewin</u>			

RECEIVED

FEB 11 1959

BUREAU V. S.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

01545

Reg. Dist. No.

1574

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN TB <b>2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>T</b> Last <b>BOCEK</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/12/12</b>	
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months <b>45</b> Days <b>45</b> Hours <b>45</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mill Hand</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Paul Bocek</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Wegczyn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>213-05-5249</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PARAVENTRICULAR TUMOR BRAIN LEFT TYPE UNSPECIFIED</b> <b>237x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>22x SUBACUTE BACTERIAL ENDOCARDITIS</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN.</b>						UNKNOWN.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>VA</b> attended the deceased from <b>January 30</b> , 19 <b>58</b> , to <b>February 1</b> , 19 <b>58</b> , and that death occurred at <b>5:10 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b> DATE SIGNED <b>2/1/58</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b>		PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-5-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Blight, Inc</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alberich</b>	

WILLIAM COOK-BLIGHT INC., 6009 HARFORD RD, BALTO., Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar or prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 13 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1575

## CERTIFICATE OF DEATH

Reg. Dist. No.

01546

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <i>Cockeysville</i>		c. LENGTH OF STAY IN 1b <i>28415</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>York Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>E.</i> Last <i>Bourquin</i>		4. DATE OF DEATH Month <i>February</i> Day <i>23</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12 August, 1871</i>
9. AGE (In years last birthday) <i>86</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Keeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Augustus Bourquin</i>		14. MOTHER'S MAIDEN NAME <i>Annie Burnham Elizabeth Merryman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Stella Kendig</i>		Address <i>576 Woodbine Ave. Towson 4, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>10 days or 10415</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/18/58</i> to <i>2/23/58</i> , that I last saw the deceased alive on <i>23 Feb</i> , 1958, and that death occurred at <i>4:58</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter T. Kees</i>		DATE SIGNED <i>2-23-58</i>	
PHYSICIAN'S NAME (Type) <i>Walter T. KEES</i>		ADDRESS (Street, city or town, state) <i>Cockeysville Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-27-58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Black Rock</i>	22d. LOCATION (City, town, or county) (State) <i>Butler, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Scott Brooks</i>		ADDRESS <i>622 York Rd., Towson 4, Md.</i>	
24a. REC'D BY REGISTRAR <i>FEB 27 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur Smith</i>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar for prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1935



Form with multiple sections for recording death information, including fields for name, date, and cause of death. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

FEB 27 1935

RECEIVED

5-27-35  
CHICK BOOK  
NEW YORK, N.Y. - TOWSON, MD.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1576

## CERTIFICATE OF DEATH

01547

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>153 Winters Lane</b>		d. STREET ADDRESS <b>153 Winters Lane</b>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>BRISCOE</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1867</b>
9. AGE (In years last birthday) yrs. <b>90</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Frederick Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry Briscoe</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>Flora Briscoe 153 Winters Lane</b>	
17. INFORMANT <b>Flora Briscoe 153 Winters Lane</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arterio-sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>8 Days</b> <b>192 Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. Arthritis</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/3/57</b> , 19____, to <b>Feb. 11/58</b> , 19____, that I last saw the deceased alive on <b>Feb. 11/58</b> , 19____, and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>C.F. Maloney, M.D. 57 Winters Lane Catonsville-28- Maryland</b> DATE SIGNED <b>Feb. 11/58</b>			
ACTUAL SIGNATURE <b>C.F. Maloney, M.D.</b>		PHYSICIAN'S NAME (Type) <b>C.F. Maloney, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mae Kate R. Williams</b>		24a. REC'D BY REGISTRAR <b>Feb 18 '58</b>	24b. REGISTRAR'S SIGNATURE <b>R. L. ...</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be obtained from hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 18 1963

BUREAU VI 21

MAYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD	
CERTIFICATE OF DEATH	
1963	
Name of Deceased: <b>John A. Smith</b>	
Date of Death: <b>February 15, 1963</b>	
Place of Death: <b>1234 Main Street, Baltimore, MD</b>	
Cause of Death: <b>Heart Disease</b>	
Age: <b>65</b>	
Sex: <b>Male</b>	
Race: <b>White</b>	
Marital Status: <b>Married</b>	
Occupation: <b>Teacher</b>	
Signature of Physician: <b>Dr. J. K. L. Smith</b>	
Signature of Registrar: <b>John A. Smith</b>	
Date of Registration: <b>February 18, 1963</b>	
Bureau VI 21	

01548

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD - G - BROWN</u>		4. DATE OF DEATH <u>Feb 11 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9 - 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>US Marine</u>	
11. BIRTHPLACE (State or foreign country) <u>Minnesota</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>199-03-248</u>	
17. INFORMANT <u>Edith M Brown</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cor Pulmonale</u> <u>527.1</u> DUE TO <u>Pulmonary Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 years</u> <u>8 - 10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 7th 1958</u> , to <u>February 11 1958</u> , that I last saw the deceased alive on <u>February 11, 1958</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md</u> DATE SIGNED <u>2-12-58</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield, M.D.</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 14 - 58</u>	<u>National Cemetery</u>	<u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Gipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <u>FEB 18 '58</u>		<u>[Signature]</u>	

VS 555 (4)  
ISM 9/55  
R 2/55

RECEIVED

1578

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Conv. Home-301 Chesapeake Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 12</b>	
		d. STREET ADDRESS <b>413 Register Ave.</b>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELENE</b> Middle Last <b>BROWN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>15,</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
13. FATHER'S NAME <b>Frederick Landt</b>		14. MOTHER'S MAIDEN NAME <b>Sophia (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Walter Gibb - 413 Register Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>443x</b> DUE TO <b>Hypertensive Decomp. Cardio Vascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 12, 1956</b> to <b>Feb 15, 1958</b> , that I last saw the deceased alive on <b>Feb 15, 1958</b> , and that death occurred at <b>3:45 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D.		ADDRESS (Street, city or town, state) <b>6805 York Rd Baltimore 12 Md</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>		DATE SIGNED <b>2-20-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/18/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Schenck &amp; Sons - Balt 17 Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Time of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	



1579

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>				d. STREET ADDRESS <u>419 S. Hanover Street</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hugh Thomas Brown</u>				4. DATE OF DEATH Month Day Year <u>February 7 1958</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 15, 1881</u>		9. AGE (In years last birthday) <u>76</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U; S. A.</u>
13. FATHER'S NAME <u>Thomas Brown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Flynn</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Records: SPRING GROVE STATE HOSPITAL</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lungs</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 7, 1951</u> , to <u>Feb. 7, 1958</u> , that I last saw the deceased alive on <u>Feb. 7, 1958</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Stella Wachslar</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Spring Grove State Hospital 2-7-58</u>			
PHYSICIAN'S NAME (Type) <u>Stella Wachslar, M. D.</u>				<u>Catonsville 28, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>2-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tracy Funeral Home - Catonsville, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alfred</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

## CERTIFICATE OF DEATH

1939

UNRECORDED

BUREAU V. S.

FEB 11 1939

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01551

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b <u>54</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>161 RIVERSIDE RD.</u>				d. STREET ADDRESS <u>161 RIVERSIDE RD</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH W BROWN</u>				4. DATE OF DEATH Month Day Year <u>FEB. 13 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 1 - 1871</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>			
11. BIRTHPLACE (State or foreign country) <u>VA.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>UNK</u>				14. MOTHER'S MAIDEN NAME <u>UNK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>JOSEPH W BROWN (SON)</u>				Address <u>SAME AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>By unknown chronic heart disease</u> 420.0 DUE TO <u>Chronic heart failure</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>30 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK C COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>FEB. 17 - 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PROVIDENT</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G Connelly</u>				ADDRESS <u>Essex 21 - Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Althea Smith</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. -File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP CODE	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		MILITARY SERVICE	
PREVIOUS ILLNESS		CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		AUTOPSY	
HISTORY OF PRESENT ILLNESS		PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS		PATHOLOGICAL FINDINGS		FINAL DIAGNOSIS	
TREATMENT		POST-MORTEM FINDINGS		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		NAME OF EXAMINER		TITLE OF EXAMINER	

BUREAU V. S.

FEB 24 1938

RECEIVED

1581  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Prince George</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>16 x 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sula</u> First <u>Bradeney</u> Middle <u>W</u> Last		4. DATE OF DEATH <u>2</u> Month <u>2</u> Day <u>19</u> Year <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-72</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>?</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>?</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Stephen</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Lee Stevens</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Samuel H Bradeney</u> Address <u>4105 Lassalle Rd., Uea</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovas. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, genl. &amp; severe</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 1, 1952</u> , to <u>Feb 2, 1958</u> , that I last saw the deceased alive on <u>Feb. 2, 1958</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslor</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove State Hosp.</u> DATE SIGNED <u>2-3-58</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachslor M.D. Catonsville 28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Cremation</u>	<u>2-5-1958</u>	<u>LONDON PARK CEM</u>	<u>BALTO 29 MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. J. Tramm</u> ADDRESS <u>3512 Frederick Court (29)</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u> 24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>	

TO HOSPITAL OR A ... HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1938

BUREAU Y. S.

FEB 3 1938

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01553

1582

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>_____</u>		d. STREET ADDRESS <u>_____</u>	
3. NAME OF DECEASED (Type or print) <u>LUCRETIA - E - BULL</u>		4. DATE OF DEATH <u>Feb 13</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 7 - 1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HUK</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Shadrach Cole</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>Charles Bull - Hampstead Rd Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per item for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic myocarditis</u> 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio Renal (Arteriosclerosis)</u> DUE TO (c) <u>Chronic Glomerular nephritis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>39</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 19 <u>48</u> , to <u>February 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>February 13</u> , 19 <u>58</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead Maryland</u> DATE SIGNED <u>2-14-58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>		<u>HAMPSTEAD MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Feb 17 - 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bleak Rock</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C. Lipton - Hampstead Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>Feb 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. Leach</u>	

CERTIFICATE OF DEATH

RECEIVED  
FEB 18 1958  
BUREAU V. A. 1  
BUREAU V. A. 1

1583

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>M Virginia</b> b. COUNTY <b>Occomack</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 6</b>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4605 Renwick Ave</b>		d. STREET ADDRESS <b>Tasley 83 X-3</b>	
3. NAME OF DECEASED (Type or print) First <b>Sallie</b> Middle <b>P</b> Last <b>Bundick</b>		4. DATE OF DEATH Month <b>2</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1897</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Va</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>James Taylor</b>		14. MOTHER'S MAIDEN NAME <b>Sallie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>William Funeral Home</b>		Address <b>Onanoke Va</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripharal Vascular Collapse + Death.</b> DUE TO <b>Left Cerebrovascular Accident RT Hemiparesis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerotic Cardiovascular Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 months 5 yrs 8 to 10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>August 20, 1957</b> , to <b>February 17, 1958</b> , that I last saw the deceased alive on <b>February 15, 1958</b> , and that death occurred at <b>6:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leonard H. Flax</b>		ADDRESS (Street, city or town, state) <b>113 7th Ave Brooklyn Park 2/19/58</b>	
PHYSICIAN'S NAME (Type) <b>Leonard H. Flax, M.D.</b>		DATE SIGNED <b>Baltimore 25g Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>2/18/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Edge Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Occomack Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm J. Beckner</b>		24. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Wm J. Beckner</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3

1958 FEB

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01555

1584

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> <u>3 Vol. 4</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7003 WARDMAN Rd</u>				d. STREET ADDRESS <u>1805 E FAIRMOUNT Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sadie Isabel Butterworth</u>				4. DATE OF DEATH Month <u>February</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-25-1880</u>		9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Lillian M.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>-</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>  <u>491x</u> DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchial Pneumonia</u>            DUE TO (c) <u>4 Days</u></p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>0</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-26-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Jenkins</u>				ADDRESS <u>490 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>	
						24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

FEB 26 1938

BUREAU V. 8

1585

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. LENGTH OF STAY IN 1b <i>53</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8401 Harford Road</i>		d. STREET ADDRESS <i>Box 38 Maryland Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Margaret</i> First Middle Last <i>Cimino</i>		4. DATE OF DEATH <i>February 27, 19 58</i> Month Day Year	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 18, 1895</i>
9. AGE (In years last birthday) <i>62</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Daniel Mc Conway</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Hughes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Vincent Cimino, Box 38 Maryland Ave.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arterio Sclerosis H D</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i> <i>15 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2-55</i> , 19 <i>58</i> , to <i>2-26</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2-26-58</i> , 19 <i>58</i> , and that death occurred at <i>3 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Jack C Collins</i>		DATE SIGNED <i>2-27-58</i>	
PHYSICIAN'S NAME (Type) <i>JACK C Collins</i>		ADDRESS (Street, city or town, state) <i>BALTIMORE</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3/3/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>DEB</i>		24b. REGISTRAR'S SIGNATURE <i>DEB</i>	
DATE <i>FEB 28 1958</i>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

FEB 28 1938

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1533

## CERTIFICATE OF DEATH

Reg. Dist. No.

01558

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> 53	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7835 Fairgreen Rd.</b>		d. STREET ADDRESS <b>7835 Fairgreen Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>KATHARINE</b> Middle <b>ELIZABETH</b> Last <b>CLAY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 12, 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Darmstadt, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>	
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Mary Hasty</b>		Address <b>7835 Fairgreen Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of the stomach</b> 151X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Nov 1957</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 17</b> , 19 <b>57</b> , to <b>Feb 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 17</b> , 19 <b>58</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3479 Liberty Pkwy. Baltimore 22, Md.</b> DATE SIGNED <b>2/21/58</b>			
ACTUAL SIGNATURE <b>Samuel J. Hawkin</b>		M.D. <b>3479 Liberty Pkwy. Baltimore 22, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Samuel J. Hawkin</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/22/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home, Dundalk, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1-63

Reg. No. 114

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
John Doe		Male		45		Jan 1, 1918		Boston, Mass.	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural	
Date of Death		Time of Death		Place of Death		Physician's Signature		Hospital or Institution	
Feb 10, 1963		10:30 AM		Home		[Signature]		None	

Name of Informant		Relationship		Address		City		State	
Jane Doe		Wife		123 Main St		Boston		Mass.	
Signature of Informant		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU Y. E.

FEB 24 1958

RECEIVED



TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO GENERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or interment.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01559

1. PLACE OF DEATH a. COUNTY <u>Balt.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balt 7</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2145 Lorraine Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>HERBERT</u> Last <u>COLBURN</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 10, 1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>worked in warehouse floor covering</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11c. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thos Colburn</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jane McCabe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>213 05-4523</u>	
17. INFORMANT <u>Herbert Colburn (Son)</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause lost. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>  </u> p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> <u>none</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>D. D. Caples</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>D. D. CAPLES</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-24-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/27/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Thos. J. Tickner &amp; Sons - Balt 17th</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>West</u>			

BUREAU V. 3

FEB 26 1958

RECEIVED

WATKINS STATE DEPARTMENT OF HEALTH - BIRMINGHAM 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
SIGNATURE OF EXAMINER		DATE		PLACE	
FEDERAL BUREAU OF INVESTIGATION		U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.	
RECEIVED		FEB 26 1958		BUREAU V. 3	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1534

CERTIFICATE OF DEATH

Reg. Dist. No.

01560

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md</b> b. COUNTY <b>Balt</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>420 Trappe Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leon</b> First <b>Collins</b> Middle Last		4. DATE OF DEATH <b>2</b> Month <b>27</b> Day <b>19-58</b> Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Black &amp; Decker</b>	
11. BIRTHPLACE (State or foreign country) <b>Phila. Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony Kalaczynski</b>		14. MOTHER'S MAIDEN NAME <b>Praxeda Laska</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-5424</b>	
17. INFORMANT <b>Mrs. Gertrude Collins</b>		Address <b>420 Trappe Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Embolism</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hypertension</b> cause (c) <b>Parkinson's Disease</b> lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio - Sclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b> <b>12 years</b> <b>3 years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 10, 1957</b> , to <b>Feb 27, 1958</b> , that I last saw the deceased alive on <b>Feb 27, 1958</b> , and that death occurred at <b>9:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris A. Jacobs</b>		ADDRESS (Street, city or town, state) <b>1010 North Point Rd. Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>MORRIS A. JACOBS</b>		DATE SIGNED <b>3/2/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 3, 58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus</b>		22d. LOCATION (City, town, or county) (State) <b>Dundalk Ave. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Search</b>	

BUREAU V. S.

555

RECEIVED  
APR 5 1968

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1587

## CERTIFICATE OF DEATH

01561

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>8 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHERYL JEAN COLVIN</b>		4. DATE OF DEATH <b>FEBRUARY 1 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 5, 1957</b>
9. AGE (In years last birthday) <b>0 yrs.</b>		10. AGE (In years last birthday) <b>9 24</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>ROY ALLEN COLVIN</b>		14. MOTHER'S MAIDEN NAME <b>Beatrice E. Stimmell</b> (from birth cer.)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>ROSEWOOD RECORDS</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>Bronchopneumonia</b> <b>759.3</b> DUE TO <b>Severe congenital malformation with hydrocephaly, microphthalmia, arrhinencephaly, double cleft palate and hare lip.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>2:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Rich. Lindenberg</b>		ADDRESS (Street, city or town, state) <b>700 Fleet Street, Balt Md</b>	
PHYSICIAN'S NAME (Type) <b>Rich. Lindenberg</b>		DATE SIGNED <b>2/3/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 5, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Owings Mills, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline, Sons Rustictown Md</b>		24a. REC'D BY REGISTRAR <b>FEB 7 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>W. H. Search</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2037264XV7



Beatrice E. Stemmiell

BUREAU V. 3

FEB 7 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film G226 3-6-58 et

1588

CERTIFICATE OF DEATH

01562

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>2yr13mth22dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Michael</b> Last <b>Connor</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 28, 1891</b>
9. AGE (In years last birthday) <b>66 84 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>scrap metal dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Connor</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Haggerty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 3, 1957</b> to <b>Feb. 24, 19 58</b> , that I last saw the deceased alive on <b>Feb. 24, 1958</b> , and that death occurred at <b>12:00a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>2-24-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>London Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna Mathison</b>		24a. REC'D BY REGISTRAR <b>FEB 27 '58</b>	
ADDRESS <b>28</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

BUREAU V. 3

FEB 27 1958

RECEIVED

1589

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE 28</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>49 Bloomsbury Ave.</u>		d. STREET ADDRESS <u>49 Bloomsbury Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>PAUL</u> Middle <u>FREDERICK</u> Last <u>COOPER</u>		4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 22, 1890.</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BUILDING TRADE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS &amp; Elec. Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK COOPER</u>		14. MOTHER'S MAIDEN NAME <u>WILHELMINA DENISE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-05-3005</u>	
17. INFORMANT <u>Mrs. Virginia Cooper</u>		Address <u>49 Bloomsbury Ave. Catonsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis Generalized</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I (a) <u>Cerebral Vascular Accident old</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>W.E. Mc Grath</u> M.D.		<u>1303 Frederick Rd. Feb 9 1958</u>	
PHYSICIAN'S NAME (Type) <u>W.E. Mc Grath</u>		<u>Catonsville 28 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>2/11/58</u>	<u>NEW CATHEDRAL CEM.</u>	<u>BALTIMORE, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. E. Mc Grath</u>

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 11 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01564

1590

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITE HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WHITE HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WILEY</u> Middle <u>ELI</u> Last <u>CORNETT</u>		4. DATE OF DEATH Month <u>2</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-4-1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WELDON CORNETT</u>		14. MOTHER'S MAIDEN NAME <u>ANGLINA ANDERSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-12-4630</u>	
17. INFORMANT <u>Mrs. Floyd Cox, White Hall Rd. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2607 Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11:10</u> to <u>3/28/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/28/58</u> , 19 <u>58</u> , and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. M. France</u> M.D.		DATE SIGNED <u>Parkton Md.</u>	
PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		<u>PARKTON MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>NEW BETHAL BAPT CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>STEWARTSTOWN, YORK CO., PA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. W. W. W.</u>		ADDRESS <u>Stewartstown Pa</u>	
24a. REC'D BY REGISTRAR <u>DATE MAR 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>	

TO HOSPITAL OR A ... DING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		MANNER OF DEATH		CAUSE OF DEATH		IMMEDIATE CAUSE		MANNER OF DEATH	
WHITE		WHITE		METHODIST		MARRIED		SUICIDE		SUICIDE		SUICIDE		SUICIDE	
EDUCATION		OCCUPATION		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		CITY OF DEATH	
HIGH SCHOOL		LABORER		JAN 6 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		MOBILE	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO		PREVIOUS OTHER		PREVIOUS OTHER	
NONE		NONE		NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF JURY	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		TIME		PLACE		CITY		STATE		COUNTRY		CITY		STATE	
JAN 6 1968		10:00 AM		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		MOBILE		ALABAMA	

BUREAU V. 1

MAR 4 1968

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1591

## CERTIFICATE OF DEATH

01565

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - WOODLAWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WOODLAWN -</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>RICE'S LANE</b>	
3. NAME OF DECEASED (Type or print) First <b>URIAH</b> Middle <b>LESLIE</b> Last <b>COX</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT 7 - 1886</b>
9. AGE (In years lost birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____	
11. IF UNDER 24 HRS. Hours _____ Min. _____		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRANSIT OPERATOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTO TRANSIT</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>URIAH COX</b>		14. MOTHER'S MAIDEN NAME <b>CORRILLA REBECCA HIPSLEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <input type="checkbox"/>	
17. INFORMANT <b>MRS FRANCES COX - RICE'S LANE - BALTO 7</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION -</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <b>1 DAY</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>JAN 5</b> , 19 <b>58</b> , to <b>FEB 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>FEB 26</b> , 19 <b>58</b> , and that death occurred at <b>7:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Thomas E. Wheeler</b>		ADDRESS (Street, city or town, state) <b>3601 Clifmar Rd - Balto 7 - 2/26/58</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 1, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bruid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Road, Randallstown, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Re...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS, COUNTY OF DALLAS, ss. I, \_\_\_\_\_, Clerk of the County Court, do hereby certify that the foregoing is a true and correct copy of the original as the same appears in the records of the County Court of Dallas County, Texas.

FEB 28 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1592

CERTIFICATE OF DEATH

01566

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2240 Monocracy Rd.</b>		d. STREET ADDRESS <b>2240 Monocracy Rd. (21)</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Fred C.</b> Middle <b>Crampton</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/6/1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David Crampton</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hayworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-05-0364A</b>	
17. INFORMANT <b>Irene Rohrig</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>356.1</b> DUE TO <b>amyotrophic lateral sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x</b> <b>Diabetic</b> <b>bulb</b>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. P. Rodgers</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>815 Eastern Ave. Balt. 21, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Wm. P. Rodgers</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>
23. HOSPITAL DIRECTOR'S SIGNATURE <b>James J. Brudzinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Outreach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. These pages remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1593

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>7 MO</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Mt. Wilson State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b> <b>3401.4</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>1231 NORTH 62<sup>ND</sup> STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>OUTLER</b> Last <b>OUTLER</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC 16, 1903</b>	
9. AGE (In years last birthday) <b>54 yrs.</b>		IF UNDER 1 YEAR Months <b>34</b> Days <b>34</b> Hours <b>34</b> Min. <b>34</b>		IF UNDER 24 HRS. Months <b>34</b> Days <b>34</b> Hours <b>34</b> Min. <b>34</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JOSEPH CROSEY</b>				14. MOTHER'S MAIDEN NAME <b>DAISY FOREMAN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> <b>002x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>TEN YEARS</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>TEN YEARS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>JULY 23, 1957</b> , to <b>FEB. 18, 1958</b> , that I last saw the deceased alive on <b>FEB 18, 1958</b> , and that death occurred at <b>1:55 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b>							
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.							
PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-20-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Czech</b> ADDRESS <b>216-18th St.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

(15)

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. B.

1958

RECEIVED

1594

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>3 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ira</b> Middle <b>F.</b> Last <b>Daniels</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>2,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Belvedere Riding Academy</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Daniels</b>		14. MOTHER'S MAIDEN NAME <b>Deliah J. Forney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Francis J. Krickbaum 4 Colonial Rd. (7)</b>	
17. INFORMANT <b>Francis J. Krickbaum</b>		Address <b>4 Colonial Rd. (7)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized</b> DUE TO (c) <b>unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Concussion &amp; Injury</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 1/30</b> , 19 <b>58</b> , to <b>Feb. 2/2</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/30</b> , 19 <b>58</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4605 Edgemoor Ave</b> DATE SIGNED <b>2/3/58</b>			
ACTUAL SIGNATURE <b>Curt Lawitt</b>		M.D. <b>4605 Edgemoor Ave</b>	
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-4-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Good Shepherd</b>	22d. LOCATION (City, town, or county) (State) <b>Howard Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b>		ADDRESS <b>3207 W. 16th Ave</b>	
24a. REC'D BY REGISTRAR <b>FEB 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mirrored and difficult to read.

BUREAU V. L.

FEB 2 1958

RECEIVED

Form with fields for signature, date, and other administrative information.



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2 DUNGARRIE RD.</u>		d. STREET ADDRESS <u>12 DUNGARRIE RD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CAROLYN LOUISE DAWSON</u>		4. DATE OF DEATH Month Day Year <u>FEB. 13, 1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 19, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>GEORGE W. DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>MR. LEROY DAWSON</u>	
17. INFORMANT <u>247 BLAKENEY RD. CATONSVILLE 28, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of cecum with metastases</u> 153.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 1, 1957</u> to <u>Feb 13, 1958</u> that I last saw the deceased alive on <u>Feb 11, 1958</u> , and that death occurred at <u>5:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John A. Nesbitt Jr.</u>		ADDRESS (Street, city or town, state) <u>1118 ST. PAUL ST.</u> DATE SIGNED <u>2-14-58</u>	
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>		<u>BALTIMORE, 2, MARYLAND</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB. 17/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR. 4101 EDMONDSON</u>		ADDRESS <u>AVE.</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Smith</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Blank form with multiple sections for recording death information, including fields for name, date, time, place, and cause of death. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

FEB 24 1938

RECEIVED

# 1 1596 1596 CERTIFICATE OF DEATH Reg. Dist. No. 01570

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN lb <b>184 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>H</b> Last <b>DAWSON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/22/89</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Wheel Wright</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Dawson</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Leng</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-10-3936</b>		17. INFORMANT <b>Clin. Rec. Div. Vets. Admin. Hospital, Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE - Left</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c) <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UNKNOWN</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that <b>VA</b> attended the deceased from <b>August 1</b> , 19 <b>57</b> to <b>February 1</b> , 19 <b>58</b> and that death occurred at <b>3:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Md.</b> DATE SIGNED <b>2/1/58</b>							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				M.D. <b>VAH Fort Howard, Md.</b>			
PHYSICIAN'S NAME (Type) <b>DONALD D. MARK, M. D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-4-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lowden Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edmund Ammaeas</b>				24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>	

ARMICOST FUNERAL HOME, 4600 Liberty Heights Ave., Balto., Md. 4 58

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01571

1577

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgemere</u>				c. LENGTH OF STAY IN 1b <u>25 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2914 Ritchie Avenue</u>				d. STREET ADDRESS <u>2914 Ritchie Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM CLYDE DEVORE</u>				4. DATE OF DEATH Month Day Year <u>February 18, 19 58</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/25/1890</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1st Helper-Open Hearth--Steel</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Ohio</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Loman Devore</u>				14. MOTHER'S MAIDEN NAME <u>Unknown MARY E. HARSHMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW1</u>				16. SOCIAL SECURITY NO. <u>213-07-3482</u>			
17. INFORMANT <u>Mable K. Devore</u>				Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Unsanitized Circumstances</u> DUE TO <u>157X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Chorea of the Hand Of The Deceased</u> DUE TO <u>4 mos</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>4 mos</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 57</u> , 19 <u>57</u> , to <u>Feb. 18</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 18</u> , 19 <u>58</u> , and that death occurred at <u>3:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>520 D. Street</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Roger Windsor M.D.</u> PHYSICIAN'S NAME (Type) <u>Roger Windsor, M.D.</u> <u>Sparrows Point 19, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/22/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Bradley</u>				ADDRESS <u>Dundalk 22, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. B. Bradley</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. 1

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1598

## CERTIFICATE OF DEATH

Reg. Dist. No.

01572

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6803 Linden Ave.</b>				d. STREET ADDRESS <b>6803 Linden Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>H.</b> Last <b>Dodson Sr.</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1879</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipe Fitter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Dodson</b>				14. MOTHER'S MAIDEN NAME <b>Unknown Casey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-4224</b>		17. INFORMANT Address <b>Mrs. Wilhelmine C. Dodson 6803 Linden Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio sclerotic Cardio Vascular Disease</b> DUE TO (c) <b>unknown</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1-3 minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Carcinoma Prostate, inoperable</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October</b> , 19 <b>57</b> , to <b>February</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>February 1</b> , 19 <b>58</b> , and that death occurred at <b>2:30 P.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6331 Belair Rd.</b> DATE SIGNED ACTUAL SIGNATURE <b>Paul G. Mueller</b> M.D. PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 4, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran</b>		22d. LOCATION (City, town, or county) (State) <b>Golden Ring Rd. Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Carohn Funeral Home</b>				ADDRESS <b>7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overlea</b>			

RECEIVED

BUREAU A

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>		c. LENGTH OF STAY IN 1b <b>31 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrison Forest Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>DOLMAGE</b> Last <b>DOLMAGE</b>		4. DATE OF DEATH <b>FEB, 15, 19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB, 16, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursing, Private</b>	
11. BIRTHPLACE (State or foreign country) <b>CaNada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>	
13. FATHER'S NAME <b>DOLMAGE</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edgar A. Poe Jr.</b>		Address <b>Garrison Forest Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331/x</b> <b>cerebral vascular accident</b> DUE TO (b) <b>arterio-sclerosis with hypertension</b> DUE TO (c) <b>15 yrs.</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 12, 19 58</b> , to <b>Feb 15, 19 58</b> , that I last saw the deceased alive on <b>Feb 11, 19 58</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John T. Williams</b>		DATE SIGNED <b>1725 Reisterstown Rd. Pikesville Md</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>2-17-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick Rd. Balto, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Powell</b>		24a. REC'D BY REGISTRAR <b>FEB 20 '58</b>	
ADDRESS <b>Pikesville</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR A ... PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, pages 1 and 2 should be filed with the registrar. Pages 1 and 2 should be removed from the certificate. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED SEX AGE DATE OF BIRTH		PLACE OF BIRTH COUNTY STATE	
OCCUPATION TRADE PROFESSION		CAUSE OF DEATH (To be filled by physician)	
DATE OF DEATH TIME OF DEATH		PLACE OF DEATH (To be filled by physician)	
SIGNATURE OF PHYSICIAN (To be filled by physician)		SIGNATURE OF REGISTRAR (To be filled by registrar)	
SIGNATURE OF WITNESS (To be filled by witness)		SIGNATURE OF DECEASED (To be filled by deceased)	
SIGNATURE OF NEXT OF KIN (To be filled by next of kin)		SIGNATURE OF BURIAL OFFICIAL (To be filled by burial official)	
SIGNATURE OF MINISTER OF THE GOSPEL (To be filled by minister of the gospel)		SIGNATURE OF CHURCH CLERK (To be filled by church clerk)	
SIGNATURE OF FUNERAL HOME (To be filled by funeral home)		SIGNATURE OF CEMETERY (To be filled by cemetery)	
SIGNATURE OF HEALTH DEPARTMENT (To be filled by health department)		SIGNATURE OF STATE DEPARTMENT OF HEALTH (To be filled by state department of health)	

**BUREAU V. S.**  
**FEB 20 1938**  
**RECEIVED**



# CERTIFICATE OF DEATH

Reg. Dist. No. 01574

VS AIS (4)  
ISM 9/SS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1601

Film G226-Item #12 - 3/14/58 mb

CERTIFICATE OF DEATH

Reg. Dist. No.

01575

1. NAME OF DECEASED (Type or Print) <b>PAULINE T. DOUKAS</b>		2. DATE OF DEATH <b>2-25-58</b>	
3. PLACE OF DEATH A. Baltimore City, Maryland <b>BALTO-MD.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO.</b>	
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>17 LINDEN TERRACE</b>		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b>	
c. Length of stay in Baltimore <b>40 years</b>		D. STREET ADDRESS (If rural, give location) <b>117 LINDEN TERRACE</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	9. AGE (In years, last birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Greece</b>
13. FATHER'S NAME <b>Basil</b>		14. MOTHER'S MAIDEN NAME <b>Konits</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Son</b>
18. <b>443x</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs.</b>	
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION	
21D. TIME (month) (day) (year) (hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <b>Jan 16, 1951</b> , to <b>Feb 25, 1958</b> that I last saw the deceased alive on <b>Feb 12, 1958</b> , and that death occurred at <b>m.</b> , from the causes and on the date stated above.		23A. SIGNATURE <b>Joseph DB King</b>	
23B. ADDRESS <b>1210 E. North - 17</b>		23C. DATE SIGNED <b>2/26/58</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>2-28-58</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Greek Cems.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>
25. FUNERAL DIRECTOR <b>Lambros Inc 440 E. North Av.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. correct age is especially important.

RECEIVED

MAR 7 1959

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1535

## CERTIFICATE OF DEATH

Reg. Dist. No. 01576

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>35 yrs.</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b> 53				d. STREET ADDRESS <b>8 Midship</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Midship</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>M Mabel G. C. Dowling</b>				4. DATE OF DEATH Month Day Year <b>February 26 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 26, 1884</b>	
9. AGE (In years lost birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ontario, Canada</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>							
13. FATHER'S NAME <b>Ambrose Edwards</b>				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Collison Bowling 4811 Eastern Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dissecting Aneurysm</b> 451X DUE TO Arteriosclerotic HD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 yrs.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>2-22</b>				20g. (County) <b>1958</b>		20h. (State) <b>2-26</b>	
21. I certify that I attended the deceased from <b>2-22</b> , 19 <b>58</b> , to <b>2-26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-25</b> , 19 <b>58</b> , and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jack C. Collins</b>				ADDRESS (Street, city or town, state) <b>2 Kinship</b>			
PHYSICIAN'S NAME (Type) <b>Jack C. Collins</b>				DATE SIGNED <b>2-27-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>March 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Homes, Dundalk, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR A ... TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

MAR 7 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01577

Reg. Dist. No.

1602

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Balto</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Baltimore</b>			c. LENGTH OF STAY in 1b <b>3 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X rural Balto</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8706 Raven Drive</b>				d. STREET ADDRESS <b>8706 Raven Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>D.</b> Last <b>Downey</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>18</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>27 Oct 1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Will Johns</b>				14. MOTHER'S MAIDEN NAME <b>Mollie D. Downey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. William M. Downey, same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis Generalized with</b> DUE TO <b>Hypertensive Cardio vascular disease</b> (c) <b>undet</b> INTERVAL BETWEEN ONSET AND DEATH <b>FEW HOURS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John C. Hyle</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>John C. Hyle</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>2-19-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR <b>20 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

-FEB 20 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01578

## 1603 CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH - COUNTY <u>1 BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MARYLAND</u> COUNTY <u>-</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shady Nook Conv. Home</u>		STREET ADDRESS (If rural, give location) <u>3614 3rd ST.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CLARA</u>	(Middle) <u>M.</u>	(Last) <u>DULL</u>
4. SEX <u>F</u>	5. COLOR OR RACE <u>W</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	7. DATE OF BIRTH <u>11-3-75</u>
8. DATE OF DEATH (Month) <u>FEB</u> (Day) <u>22</u> (Year) <u>1958</u>	9. AGE last birthday <u>82</u> yrs.	10. If under 1 year Months <u>  </u> Days <u>  </u>	11. If under 24 hrs. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, given if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Geo. Leiman</u>		14. MOTHER'S MAIDEN NAME <u>MARY FITZPATRICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Family</u> <u>Same</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

421. Immediate cause

(b) CALCIFIC AORTIC STENOSIS

YEARS

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(a) CONGESTIVE HEART FAILURE

UNKNOWN

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/13, 1958, to 2/22, 1958, that I last saw the deceasedalive on 2/22, 1958, and that death occurred at 4:25 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-25-58</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	LOCATION (City, town, or county) <u>BALTIMORE, MD.</u>	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
		<u>McGully Funeral Homes</u>	<u>130 E. Fort Ave</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2000





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 01579

1604

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Nursing Home</b>				d. STREET ADDRESS <b>5110 Whiteford Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>J.</b> Last <b>Dumler</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/17/1868</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Stephen D. Flaherty</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Hopkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mrs George Maynes 5110 Whiteford Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Decompensative Cardio Vascular</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Dec 10</b> , 19 <b>57</b> , to <b>Feb 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 8</b> , 19 <b>58</b> , and that death occurred at <b>3:45 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D.				ADDRESS (Street, city or town, state) <b>6805 York Rd. Baltimore 12 Md.</b>			
DATE SIGNED							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/11/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran 3000 E. Baltimore St.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH Baltimore		COUNTY Baltimore	
NAME OF DECEASED John A. Korte		SEX Male	
DATE OF DEATH February 19, 1958		TIME OF DEATH 11:00 AM	
PLACE OF BIRTH Baltimore		AGE 68	
OCCUPATION Retired		CAUSE OF DEATH Heart Disease	
MEDICAL HISTORY Hypertension		PRESENT ILLNESS Angina Pectoris	
PHYSICIAN Dr. J. A. Korte		SECOND PHYSICIAN Dr. J. A. Korte	
BURIAL PLACE St. Mary's Cemetery		NAME OF FUNERAL HOME St. Mary's Funeral Home	
SIGNATURE OF DECEASED John A. Korte		SIGNATURE OF PHYSICIAN Dr. J. A. Korte	
SIGNATURE OF SECOND PHYSICIAN Dr. J. A. Korte		SIGNATURE OF FUNERAL HOME St. Mary's Funeral Home	

BUREAU V. 3

FEB 19 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1544									
Reg. Dist. No. 01580									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b> c. LENGTH OF STAY IN 1b <b>5/</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>4610 Linden Ave.</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b> d. STREET ADDRESS <b>4610 Linden Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>C.</b> Last <b>EBERT</b>					4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1958</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 2, 1887</b>		9. AGE (In years last birthday) <b>70</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>--Ebert</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Mary L. Ebert, 2024 Orleans St. 31</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Extensive Crushing Injury of Body</b> <b>802X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Pedestrian hit by train</b>							
20c. TIME OF INJURY Month, Day, Year <b>3:57</b> <b>2/12/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>railroad</b>		20f. (City or town) <b>Halethorpe</b>		20g. (County) <b>Baltimore</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/12/58</b>					
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 14/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto. Md.</b>		22e. (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip's Funeral Home</b>				ADDRESS <b>2024 Orleans St. 31</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 18 1933

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01582

Reg. Dist. No.

1536

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK 22 53</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6842 DUNBAR RD</u>				d. STREET ADDRESS <u>6842 DUNBAR RD</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>EDGAR WOODEND EDMONDSON</u>				4. DATE OF DEATH <u>2/17/58</u> 19			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 12, 1885</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Edmondson</u>				14. MOTHER'S MAIDEN NAME <u>Isabel Postelthwaite</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>213-07-8828</u>		17. INFORMANT <u>Winifred Edmondson</u> Address <u>Same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Jack E Collins</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>JACK E COLLINS</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/21/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Dorsey, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter R. Bradley</u> ADDRESS <u>Dundalk, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, and cause of death. The form is mostly blank with some faint markings.

BUREAU Y. B.

FEB 24 1958

RECEIVED



BEYOND

BUREAU V. S.

FEB 28 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1606

## CERTIFICATE OF DEATH

Reg. Dist. No. 01584

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ridgeway Manor 5743 Edmondson Avenue</i>		d. STREET ADDRESS <i>3605 Dudley Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Flora J. Engel</i>		4. DATE OF DEATH <i>February 14th 1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 11, 1876</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Vienna, Austria</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Florian Lara</i>		14. MOTHER'S MAIDEN NAME <i>Emma Ruf</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Mr. Wm. F. Engel, 7608 Bagley Avenue</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic Hypertensive Cardiovascular Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> 1077	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>11-17</i> , 1955, to <i>2-14</i> , 1958, that I last saw the deceased alive on <i>2-13</i> , 1958, and that death occurred at <i>6:50 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i>		ADDRESS (Street, city or town, state) <i>6209 Frederick Road, Baltimore, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>Wilmer K. Gallagher</i>		DATE SIGNED <i>2/14/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/17/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem Park</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>FEB 18 '58</i>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED  
FEB 18 1933  
BUREAU V. S.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Stevenson</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Hillside Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Henry Esworthy</u>		4. DATE OF DEATH Month Day Year <u>February 24 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 5 1900</u>
9. AGE (In years, last birthday) <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Liberia, Md.</u>	
13. FATHER'S NAME <u>John Esworthy</u>		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Valvular Heart Disease</u> <u>421.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Emphysema, bronchitis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>1958</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>58</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mr. E. J. Martin</u>		ADDRESS (Street, city or town, state) <u>Randallstown</u>	
PHYSICIAN'S NAME (Type) <u>W. E. MARTIN</u>		DATE SIGNED <u>Feb 24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 26, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Carroll's Chapel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Luttrell, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank J. Newell, Pittsill, Md.</u>		24. REC'D BY REGISTRAR <u>DATE FEB 27 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>Asst. Comm.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

FEB 27 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1608

## CERTIFICATE OF DEATH

01586

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockdale</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3620 Langrehr Road</b>		d. STREET ADDRESS <b>3620 Langrehr Road</b>	
e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
3. NAME OF DECEASED (Type or print) First <b>Edgar</b> Middle <b>A. Euler Sr.</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>20,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 25, 1893</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11. BIRTHPLACE (State or foreign country) <b>Rockdale, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John A. Euler</b>		14. MOTHER'S MAIDEN NAME <b>Mary Glanzer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-03-4110</b>	
17. INFORMANT <b>Mrs. Dorothy M. Euler</b>		Address <b>3620 Langrehr Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June</b> , 19 <b>52</b> to <b>February 10, 1958</b> , that I last saw the deceased alive on <b>February 10, 1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edwin L. Pierpont</b>		DATE SIGNED <b>8204 LIBERTY RD, BALTO, MD 21215</b>	
PHYSICIAN'S NAME (Type) <b>Edwin L. Pierpont 8204 Liberty Road, Balto. 7, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/24/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Randallstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b>		ADDRESS <b>8728 Liberty Road</b>	
24a. REC'D BY REGISTRAR <b>FEB 23 58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

Randallstown, Maryland

TO HOSPITAL OR A FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1609

## CERTIFICATE OF DEATH

Reg. Dist. No. **01587**

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			c. LENGTH OF STAY IN 1b <b>1</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7720 Trappe Road</b>				d. STREET ADDRESS <b>7720 Trappe Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <b>EDWARD C. FECHTER</b> <span style="float: right;">First Middle Last</span>				<b>4. DATE OF DEATH</b> <b>FEBRUARY 20, 1958</b> <span style="float: right;">Month Day Year</span>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>Jan. 10, 1879</b>		<b>9. AGE</b> (In years and birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Clerk</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Lord Balto. Hotel</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Germany</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>
<b>13. FATHER'S NAME</b> <b>? Fechter</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>216-03-3685A</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mrs. Edna M. Hughes-7720 Trappe Road 2.22</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HYPERTENSIVE CARDI</b> <b>443X</b> DUE TO <b>VASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from <u>2-4</u>, 1958, to <u>2-20</u>, 1958, that I last saw the deceased alive on <u>2-20-58</u>, 1958, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.</b>							
<b>ACTUAL SIGNATURE</b> <b>LEZAROWICZ</b> M.D.				<b>ADDRESS</b> (Street, city or town, state) <b>DR. W. E. BAERMANN</b> <b>33 DUNDALK AVENUE</b> <b>DUNDALK 22, MARYLAND</b>			
<b>PHYSICIAN'S NAME</b> (Type)				<b>DATE SIGNED</b>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>2/24/58</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Parkwood Cemetery</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John A. Moran - 3000 E. Baltimore Street</b>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 25 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH HOSPITAL		2. NAME OF DECEASED EDWARD J. YOUNG	
3. SEX Male		4. AGE 32	
5. RACE White		6. DATE OF DEATH Feb 22 1933	
7. TIME OF DEATH 10:30 AM		8. PLACE OF BIRTH Baltimore, Md.	
9. OCCUPATION None		10. CAUSE OF DEATH Pneumonia	
11. DISEASE OR INJURY Pneumonia		12. SIGNATURE OF PHYSICIAN J. H. Smith	
13. SIGNATURE OF WITNESSES J. H. Smith		14. SIGNATURE OF DECEASED None	
15. SIGNATURE OF FUNERAL HOME None		16. SIGNATURE OF BURIAL PLACE None	
17. SIGNATURE OF REGISTRAR None		18. SIGNATURE OF CLERK None	
19. SIGNATURE OF ASSISTANT CLERK None		20. SIGNATURE OF CHIEF CLERK None	
21. SIGNATURE OF DEPUTY CLERK None		22. SIGNATURE OF ASSISTANT DEPUTY CLERK None	
23. SIGNATURE OF CLERK IN CHARGE None		24. SIGNATURE OF CLERK IN CHARGE None	
25. SIGNATURE OF CLERK IN CHARGE None		26. SIGNATURE OF CLERK IN CHARGE None	
27. SIGNATURE OF CLERK IN CHARGE None		28. SIGNATURE OF CLERK IN CHARGE None	
29. SIGNATURE OF CLERK IN CHARGE None		30. SIGNATURE OF CLERK IN CHARGE None	
31. SIGNATURE OF CLERK IN CHARGE None		32. SIGNATURE OF CLERK IN CHARGE None	
33. SIGNATURE OF CLERK IN CHARGE None		34. SIGNATURE OF CLERK IN CHARGE None	
35. SIGNATURE OF CLERK IN CHARGE None		36. SIGNATURE OF CLERK IN CHARGE None	
37. SIGNATURE OF CLERK IN CHARGE None		38. SIGNATURE OF CLERK IN CHARGE None	
39. SIGNATURE OF CLERK IN CHARGE None		40. SIGNATURE OF CLERK IN CHARGE None	
41. SIGNATURE OF CLERK IN CHARGE None		42. SIGNATURE OF CLERK IN CHARGE None	
43. SIGNATURE OF CLERK IN CHARGE None		44. SIGNATURE OF CLERK IN CHARGE None	
45. SIGNATURE OF CLERK IN CHARGE None		46. SIGNATURE OF CLERK IN CHARGE None	
47. SIGNATURE OF CLERK IN CHARGE None		48. SIGNATURE OF CLERK IN CHARGE None	
49. SIGNATURE OF CLERK IN CHARGE None		50. SIGNATURE OF CLERK IN CHARGE None	
51. SIGNATURE OF CLERK IN CHARGE None		52. SIGNATURE OF CLERK IN CHARGE None	
53. SIGNATURE OF CLERK IN CHARGE None		54. SIGNATURE OF CLERK IN CHARGE None	
55. SIGNATURE OF CLERK IN CHARGE None		56. SIGNATURE OF CLERK IN CHARGE None	
57. SIGNATURE OF CLERK IN CHARGE None		58. SIGNATURE OF CLERK IN CHARGE None	
59. SIGNATURE OF CLERK IN CHARGE None		60. SIGNATURE OF CLERK IN CHARGE None	
61. SIGNATURE OF CLERK IN CHARGE None		62. SIGNATURE OF CLERK IN CHARGE None	
63. SIGNATURE OF CLERK IN CHARGE None		64. SIGNATURE OF CLERK IN CHARGE None	
65. SIGNATURE OF CLERK IN CHARGE None		66. SIGNATURE OF CLERK IN CHARGE None	
67. SIGNATURE OF CLERK IN CHARGE None		68. SIGNATURE OF CLERK IN CHARGE None	
69. SIGNATURE OF CLERK IN CHARGE None		70. SIGNATURE OF CLERK IN CHARGE None	
71. SIGNATURE OF CLERK IN CHARGE None		72. SIGNATURE OF CLERK IN CHARGE None	
73. SIGNATURE OF CLERK IN CHARGE None		74. SIGNATURE OF CLERK IN CHARGE None	
75. SIGNATURE OF CLERK IN CHARGE None		76. SIGNATURE OF CLERK IN CHARGE None	
77. SIGNATURE OF CLERK IN CHARGE None		78. SIGNATURE OF CLERK IN CHARGE None	
79. SIGNATURE OF CLERK IN CHARGE None		80. SIGNATURE OF CLERK IN CHARGE None	
81. SIGNATURE OF CLERK IN CHARGE None		82. SIGNATURE OF CLERK IN CHARGE None	
83. SIGNATURE OF CLERK IN CHARGE None		84. SIGNATURE OF CLERK IN CHARGE None	
85. SIGNATURE OF CLERK IN CHARGE None		86. SIGNATURE OF CLERK IN CHARGE None	
87. SIGNATURE OF CLERK IN CHARGE None		88. SIGNATURE OF CLERK IN CHARGE None	
89. SIGNATURE OF CLERK IN CHARGE None		90. SIGNATURE OF CLERK IN CHARGE None	
91. SIGNATURE OF CLERK IN CHARGE None		92. SIGNATURE OF CLERK IN CHARGE None	
93. SIGNATURE OF CLERK IN CHARGE None		94. SIGNATURE OF CLERK IN CHARGE None	
95. SIGNATURE OF CLERK IN CHARGE None		96. SIGNATURE OF CLERK IN CHARGE None	
97. SIGNATURE OF CLERK IN CHARGE None		98. SIGNATURE OF CLERK IN CHARGE None	
99. SIGNATURE OF CLERK IN CHARGE None		100. SIGNATURE OF CLERK IN CHARGE None	

BUREAU V. S.

FEB 25 1933

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1610 CERTIFICATE OF DEATH

Reg. Dist. No. 01588

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OVERLEA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OVERLEA MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>26 GLEN MORE AVE</b>		d. STREET ADDRESS <b>26 GLEN MORE AVE</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERNARD J. FEEHLEY SR</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 5 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 23 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FOREMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STANDARD OIL CO</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM FEEHLEY</b>		14. MOTHER'S MAIDEN NAME <b>MAMIE STRECKFUS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>214-01-4205</b>	
17. INFORMANT <b>BARBARA C. FEEHLEY</b>		Address <b>26 GLEN MORE AVE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Cardio-Vascular Hypertensive Disease</b> DUE TO <b>10 yrs.</b> (c) <b>Arteriosclerosis</b> <b>10 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 26</b> , 1954, to <b>Feb 5</b> , 1958, that I last saw the deceased alive on <b>Feb 5</b> , 1958, and that death occurred at <b>9:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Michael J. Dausch</b> M.D.		ADDRESS (Street, city or town, state) <b>4636 Belair Road</b> DATE SIGNED <b>Feb 5, 1958</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB 8 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>PARK WOOD CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>TAYLOR BALTO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clifford B. ...</b>		ADDRESS <b>7110 BELAIR ROAD</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Dausch</b>	



1611

CERTIFICATE OF DEATH

Reg. Dist. No. 01589

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7918 Subet Road</u>		d. STREET ADDRESS <u>7213 Yosemite Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Adolph</u> Middle <u>-</u> Last <u>Feit</u>		4. DATE OF DEATH Month <u>2-</u> Day <u>1-</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-1904</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Drapery</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac</u>		14. MOTHER'S MAIDEN NAME <u>Moelie</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Jeannine Feit - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 ACUTE CORONARY OCCLUSION</u> DUE TO (b) <u>ARTERIO SCLEROTIC CARDIOVASC. DISEASE</u> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>October</u> , 1957, to <u>Feb. 1</u> , 1958, that I last saw the deceased alive on <u>JAN. 2</u> , 1958, and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Deckerbaum</u> M.D.		ADDRESS (Street, city or town, state) <u>4017 Liberty Heights</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH DECKERBAUM, M.D.</u>		DATE SIGNED <u>2/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-2-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rosedale</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>JACK LEWIS INC</u>		ADDRESS <u>2100 Britton Place</u>	
24a. REC'D BY REGISTRAR <u>FEB 4 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1612

CERTIFICATE OF DEATH

01590

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armcast Nursing Home-612 Register Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>KATHRYN</b> Middle <b>D. FELTON</b> Last				4. DATE OF DEATH Month <b>Feb.</b> Day <b>12,</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 27, 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Pa.</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Patrick Sullivan</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Cummings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>343-16-2480A</b>		17. INFORMANT <b>Miss Mildred M. Griffin - 181 Dumbarton Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO <b>with Decomensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemiplegia, lower extremities</b> DUE TO (c) <b>Multiple Myeloma with collapse lower vertebrae</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b> <b>9 mos.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 1957</b> , to <b>Feb 12, 1958</b> , that I last saw the deceased alive on <b>Feb. 8</b> , 19 <b>58</b> , and that death occurred at <b>2 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm H Kammer Jr.</b> M.D. <b>6011 York Rd. Balto. 12, Md.</b>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Wm. H. Kammer, Jr.</b>				<b>6011 York Rd. Balto. 12, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/13/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Seranton, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Sicker</b> ADDRESS <b>Wm. J. Sicker</b> DATE <b>FEB 14 '58</b>							

TO HOSPITAL OR FUNERAL HOME: This low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director. Pages 1 and 2 should be filed with the funeral director.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

FEB 14 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01591

1613

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7907 Belair Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>M.</u> Last <u>Fink</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>3,</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 12, 1877</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert A. Holthaus</u>		14. MOTHER'S MAIDEN NAME <u>Maria Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Albert A. Holthaus</u>		Address <u>7907 Belair Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Atherosclerosis &amp; Hypertension</u> DUE TO (c) <u>undet.</u> INTERVAL BETWEEN ONSET AND DEATH <u>40 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>NOON Feb 1, 19 58</u> to <u>10:40 Feb 3, 19 58</u> , that I last saw the deceased alive on <u>1 Feb 19 58</u> , and that death occurred at <u>10:40 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John C. Hyle</u>		M.D. <u>7527 Belair Rd Balt 6 Md</u>	
PHYSICIAN'S NAME (Type) <u>John C. Hyle</u>		DATE SIGNED <u>4 Feb 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Turel Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE 6 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overman</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

REG. NO. 11

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		W		1880		BALTIMORE, MD.		FEB 6 1939		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	
13. FULL NAME OF DECEASED		14. SEX		15. AGE		16. RACE		17. DATE OF BIRTH		18. PLACE OF BIRTH		19. DATE OF DEATH		20. PLACE OF DEATH		21. CAUSE OF DEATH		22. MANNER OF DEATH		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF REGISTRAR	
JAMES H. HARRIS		M		45		W		1880		BALTIMORE, MD.		FEB 6 1939		BALTIMORE, MD.		HEART DISEASE		NATURAL		J. H. HARRIS		J. H. HARRIS	

BUREAU V. 2

FEB 6 1939

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01592

1. NAME OF DECEASED (Type or Print) <b>THOMAS E. FITCH Jr.</b>			2. DATE OF DEATH <b>2/16/58</b>		
3. PLACE OF DEATH: A. Baltimore City, Maryland			4. USUAL RESIDENCE A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fitch Lane - Fullerton</b>			C. CITY OR TOWN <b>Fullerton</b>		
D. STREET ADDRESS (If rural, give location) <b>Box 502 Fitch Lane</b>			E. LENGTH OF STAY IN BALTIMORE <b>Life</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Nov. 13, 1911</b>		9. AGE (In years last birthday) <b>46</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Building Supplies</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>
13. FATHER'S NAME <b>Thomas E. Fitch Sr.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-18-2635</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. McLean</b>
17. INFORMANT <b>Mrs. Dolores E. Fitch-Box 502 Fitch Lane</b>			ADDRESS		

18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CRUSHING INJURY OF ABDOMEN</b>		INTERVAL BETWEEN ONSET AND DEATH
(A) DUE TO <b>912.5 ANTECEDENT CAUSES</b>		
(B) DUE TO		
(C) DUE TO		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Acute Alcoholism</b>	
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19. DATE OF OPERATION <b>2-16-58</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <b>STREET</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>501 FITCH Lane</b>		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Fell under Snow Plow</b>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <b>2-16-58 6:30 PM</b>		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell under Snow Plow</b>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
23A. SIGNATURE <b>[Signature]</b>		23B. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER <b>[Signature]</b>		23C. DATE SIGNED <b>2-17-58</b>

24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Feb. 20, 1958</b>	24C. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's</b>	24D. LOCATION (City, town, or county) (State) <b>Fullerton, Md.</b>
DATE RECEIVED BY REGISTRAR <b>FEB 19 1958</b>		25. FUNERAL DIRECTOR <b>[Signature]</b>	
REGISTRAR'S SIGNATURE <b>[Signature]</b>		ADDRESS <b>7401 Blair Rd</b>	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WRITE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly.

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d be

TO DEPUTY MEDICAL EXAMINER

VS



*[The page contains faint, illegible text, likely bleed-through from the reverse side.]*

1615

CERTIFICATE OF DEATH

01593

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baeto Md</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>Baeto</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>52</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>90 Wayne's Home</i>		d. STREET ADDRESS <i>Catonville</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harry E Flowers</i>		4. DATE OF DEATH Month Day Year <i>2 18 1958</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 9 1892</i>
9. AGE (in years last birthday) yrs. <i>85</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Homes</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>JAMES Flowers</i>		14. MOTHER'S MAIDEN NAME <i>NANCY Sing Le Roy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>Edna Klapaska</i>	
17. INFORMANT <i>Edna Klapaska</i>		Address <i>Glen Arm Rd Hyde Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Generalized Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>chronic recurrent Melanch</i> (c) <i>cause undetermined</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 57</i> , 19 <i>57</i> , to <i>2/18/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/16/58</i> , 19 <i>58</i> , and that death occurred at <i>1000 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>W. E. McGrath</i> M.D.		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd Catonsville 28 Md</i>	
DATE SIGNED <i>2/20/58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2-22-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>FORK Methodist</i>	22d. LOCATION (city, town, or county) (State) <i>FORK Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>CHAS F. EVANS + SON</i> ADDRESS <i>8802 HARTFORD Rd</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 24 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Overman</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01594**

1616

FOR STATE HEALTH DEPT.

M

I

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN lb <b>LIFE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWSON</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>404 RAILROAD AVE</b>				d. STREET ADDRESS <b>404 RAILROAD AVE.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RACHEL E. FRAZIER</b>				4. DATE OF DEATH <b>February 21 19 58</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 3, 1865</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE (HOUSEWIFE)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>							
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>CLARA JOHNSON, 404 RAILROAD AVE.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>491X</b> <b>Bronchial Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>INTERVAL BETWEEN ONSET AND DEATH 1 WEEK</b> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT REST</b>		22d. LOCATION (City, town, or county) (State) <b>TOWSON, BALTO. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chas. J. Chetman</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. J. Chetman</b>	

WESTLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF  
DATE

RECEIVED  
FEB 28 1953  
BUREAU V.

FROM



1617 CERTIFICATE OF DEATH

Reg. Dist. No. 01595

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ashland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sunnybrook Road</b>				d. STREET ADDRESS <b>Sunnybrook Road</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>DANIEL EDWARD FREELAND</b>				4. DATE OF DEATH Month Day Year <b>February 18, 1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 23, 1882</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer- retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Co. Dist.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Freeland</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Leo Freeland, Ashland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1, 1958</b> , to <b>Feb 18, 1958</b> , that I last saw the deceased alive on <b>Feb 18, 1958</b> , and that death occurred at <b>10 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>William A. Pillsbury</b>				DATE SIGNED <b>2/20/58</b>			
PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>				M.D. <b>T. J. Quinn M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 22, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Poplar Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Quinn</b>	

RECEIVED

FEB 24 1958

BUREAU V. S.

CERTIFICATE OF DEATH

1017

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

5 1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01596

Reg. Dist. No.

1618

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase (West Twin River)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase (West Twin River)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Gundale Ave.</b>		e. STREET ADDRESS <b>Gundale Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>William Rupert Freeland</b>		4. DATE OF DEATH <b>February 16, 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 28, 1887</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
15. FATHER'S NAME <b>John Freeland</b>		16. MOTHER'S MAIDEN NAME <b>Indiana Peterson</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WWI</b>		18. SOCIAL SECURITY NO. <b>215-10-6687</b>	
19. INFORMANT <b>Vera M Freeland</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>416x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>None</b>			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>M. B. Davis</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>M. B. Davis M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mays Chapel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Timonium, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Bruzdinski</b>		ADDRESS <b>1407 Eastern Ave.</b>	
24a. REC'D BY REGISTRAR <b>FEB 19 '58</b>		DATE <b>2/16/58</b>	
24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH OFFICE

BUREAU V. S.  
FEB 19 1938

RECEIVED

1619

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Balto.</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Balto</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Convalescent Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>ANNE J GAIERTY</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Feb 23 1958</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>SW</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-5-1867</u>	
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Patrick Gaierly</u>		14. MOTHER'S MAIDEN NAME <u>Julia Mathieu</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs Mary Furst 611 Winston Ave Balto Md</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arterio-sclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac De-compensation</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>Feb. 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 22</u> , 19 <u>58</u> , and that death occurred at <u>12:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thos. A. SETHLACK</u>				ADDRESS (Street, city or town, state) <u>200 W. Penna Ave Towson 4, Md</u>			
PHYSICIAN'S NAME (Type) <u>Thos. A. SETHLACK</u>				DATE SIGNED <u>2/24/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>General</u>		22b. DATE THEREOF <u>Feb 26 58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins</u>				ADDRESS <u>10649 1/2 York Rd</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. S. Beach</u>				24c.			

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

FEB 26 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1620

## CERTIFICATE OF DEATH

Reg. Dist. No.

01598

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. LENGTH OF STAY IN TB <b>20 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Box 13 E. Joppa Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>L.</b> Last <b>Gardner</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>4,</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 3, 1915</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Christiana Knopp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-07-5543</b>	
17. INFORMANT <b>Mrs. Ella E. Gardner</b> Address <b>Box 13 E. Joppa Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Coronary Thrombosis</b> (c) <b>arterial sclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>15 Aug, 1957</b> to <b>21 Jan, 1958</b> , that I last saw the deceased alive on <b>21 Jan, 1958</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		ADDRESS (Street, city or town, state) <b>6801 Belair Rd Baltimore</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>WYMAN K. WONG</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 7, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Belair Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Belair, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b> ADDRESS <b>7401 Belair Rd</b>		24a. REC'D BY REGISTRAR <b>[Signature]</b> DATE <b>FEB 7 '58</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 7 1952

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01599

1621

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>BALTIMORE CITY</b> 3Y01-4			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				d. STREET ADDRESS <b>814 W. 37<sup>TH</sup> STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>EMERSON</b> Middle <b>RUSSELL</b> Last <b>GARRISON</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>21</b> Year <b>1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JULY 4 1908</b>	
9. AGE (In years last birthday) <b>49</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFEUR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TRUCK DRIVER</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH T. GARRISON</b>				14. MOTHER'S MAIDEN NAME <b>CARRIE SHIPLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>215-01-0414</b>			
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNCERTAIN</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				20g. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>2/13</b> , 19 <b>58</b> , to <b>2/21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/21</b> , 19 <b>58</b> , and that death occurred at <b>2:20</b> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Mt. Wilson, Maryland</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M. D., Superintendent</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stuid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Belleville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance E. Donovan</b> ADDRESS <b>3818 Roland Ave</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Qu. Branch</b>	

## 154

*[Faint handwritten text at the bottom of the page]*

1952 WHITE - 1950 1000 4 1958

Joseph T. Garrison  
Treasurer

211-01-014

PRIMARY TUBERCULOSIS

BUREAU W. 11

FEB 24 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1622

## CERTIFICATE OF DEATH

01600

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baets Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baets Co</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>University Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sophie K Garvey</u>		4. DATE OF DEATH <u>Feb 16 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/30/1911</u> 9. AGE (In years last birthday) <u>46</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Phillip Hedderich</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Schmidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Henry H Garvey</u>	
17. INFORMANT <u>Henry H Garvey</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the uterine cervix with</u> <u>171X</u> DUE TO <u>Metastases to the rectum and vulva</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-21-55</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>
21. I certify that I attended the deceased from <u>Oct. 21 1955</u> to <u>Feb 16</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 15, 1958</u> , 19 <u>58</u> , and that death occurred at <u>7:45 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11 E. Chase St Balto. 2, Maryland</u> DATE SIGNED <u>Feb 19, 1958</u>			
ACTUAL SIGNATURE <u>William J. Sullivan</u> M.D.		PHYSICIAN'S NAME (Type) <u>William J. Sullivan M. D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2/20/58</u>	<u>Cathedral</u>	<u>Baets Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Habb &amp; Son</u> ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF REGISTRAR		15. SIGNATURE OF WITNESSES	

10-21-58

Continuation of the electronic death certificate to the death and vital records section

BUREAU V. 8

FEB 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01601

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO-</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK - VV</b>		c. LENGTH OF STAY IN 1b <b>53</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK - VV - 53</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7234 MARTELL AVE</b>				d. STREET ADDRESS <b>7234 MARTELL AVE</b>			
3. NAME OF DECEASED (Type or print) <b>JONATHAN</b> First <b>GERMAN</b> Middle Last				4. DATE OF DEATH <b>2/2/58</b> Month Day Year			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>OCT 29, 1904</b>		9. AGE (In years and months) <b>53</b> yrs.	10. UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAPER HANGER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SELF</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Irving Miller German</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Krodell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-12-1285</b>		17. INFORMANT <b>Mrs ETTA Gosker 3908 Keyon Ave</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>M B Davis</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>MB DAVIS MD</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ROSDEN PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. FARACE, INC. BALTO, MD</b>				24a. REC'D BY REGISTRAR <b>Feb 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rehman</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

EB 4 1968

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01602

1623

<b>1. PLACE OF DEATH</b> a. COUNTY <i>Balto.</i> <span style="float: right;">MARYLAND</span>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Balto. 7</i>		c. LENGTH OF STAY IN 1b <i>30 yrs</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2000 Thayer Terrace</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <i>JOSEPH ANTHONY GERMAK</i>		<b>4. DATE OF DEATH</b> Month Day Year <i>Feb. 5 1958</i>	
<b>5. SEX</b> <i>Male</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <i>Jan 26, 1892</i>
<b>9. AGE</b> (In years last birthday) <i>66 yrs.</i>		<b>10. IF UNDER 1 YEAR</b> IF UNDER 24 HRS. Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>machine manufacturing - making valves</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>Balto. Md.</i>	
<b>11. BIRTHPLACE</b> (State or foreign country) <i>U.S.A.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>U.S.A.</i>	
<b>13. FATHER'S NAME</b> <i>JOHN GERMAK</i>		<b>14. MOTHER'S MAIDEN NAME</b> <i>KATHERINE KEAL</i>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <i>no.</i>		<b>16. SOCIAL SECURITY NO.</b> <i>212-07-5802A</i>	
<b>17. INFORMANT</b> Address <i>Edna. Germak - 2000 Thayer Terrace</i>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>arteriosclerotic C-V. Disease</i> DUE TO (b) <i>Generalized arteriosclerosis</i> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>none</i>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <i>9 Feb 5 1958</i>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <i>none</i>		<b>20f. (City or town) (County) (State)</b> <i>none</i>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
<b>ACTUAL SIGNATURE</b> <i>D. D. Caples</i>		<b>DATE SIGNED</b> <i>2-5-58</i>	
<b>EXAMINER'S NAME (Type)</b> <i>D. D. CAPLES</i>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <i>BURIAL</i>		<b>22b. DATE THEREOF</b> <i>2/8/58</i>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <i>LORRAINE</i>		<b>22d. LOCATION (City, town, or county) (State)</b> <i>WOODCLAWN MD.</i>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <i>JOHN T. STANSBURY</i>		<b>ADDRESS</b> <i>BALTO 7, MD.</i>	
<b>24a. REC'D BY REGISTRAR</b> <i>FEB 7 58</i>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>W. H. Keach</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

FEB 7 1958

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1

CERTIFICATE OF DEATH

01603

Reg. Dist. No.

1624

1. PLACE OF DEATH a. COUNTY <b>BALTO</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b> c. LENGTH OF STAY IN 1b <b>5 YRS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTO.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>54 Essex</b> d. STREET ADDRESS <b>1954 ARNCLIFFE RD.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ROSANNA GILPIN</b> First Middle Last 4. DATE OF DEATH <b>2 - 5 1958</b> Month Day Year		5. SEX <b>F</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Dec 2 - 1898</b> 9. AGE (In years last birthday) <b>59</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House-Wife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>AT-Home</b> 11. BIRTHPLACE (State or foreign country) <b>PA.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.C.</b>		13. FATHER'S NAME <b>Curtis</b> 14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <b>Husband</b> Address <b>SAME</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY Embolism</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease, with Auricular Fibrillation unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>OBESITY - Hypertensive CVD</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>2/1 1958</b> to <b>2/5 1958</b> , that I last saw the deceased alive on <b>2/4/58</b> , 19 <b>58</b> , and that death occurred at <b>4:00 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John E. Gessner</b> M.D. PHYSICIAN'S NAME (Type) <b>John E. Gessner</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b> 22b. DATE THEREOF <b>2/10/58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Arlington-National</b> 22d. LOCATION (City, town, or county) (State) <b>Washington D. C.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly - Essex - Md.</b> ADDRESS 24a. REC'D BY REGISTRAR <b>DATE 11 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF JUDGE		15. SIGNATURE OF CLERK		16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK		19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF CLERK		21. SIGNATURE OF CLERK		22. SIGNATURE OF CLERK		23. SIGNATURE OF CLERK		24. SIGNATURE OF CLERK		25. SIGNATURE OF CLERK		26. SIGNATURE OF CLERK		27. SIGNATURE OF CLERK		28. SIGNATURE OF CLERK		29. SIGNATURE OF CLERK		30. SIGNATURE OF CLERK		31. SIGNATURE OF CLERK		32. SIGNATURE OF CLERK		33. SIGNATURE OF CLERK		34. SIGNATURE OF CLERK		35. SIGNATURE OF CLERK		36. SIGNATURE OF CLERK		37. SIGNATURE OF CLERK		38. SIGNATURE OF CLERK		39. SIGNATURE OF CLERK		40. SIGNATURE OF CLERK		41. SIGNATURE OF CLERK		42. SIGNATURE OF CLERK		43. SIGNATURE OF CLERK		44. SIGNATURE OF CLERK		45. SIGNATURE OF CLERK		46. SIGNATURE OF CLERK		47. SIGNATURE OF CLERK		48. SIGNATURE OF CLERK		49. SIGNATURE OF CLERK		50. SIGNATURE OF CLERK		51. SIGNATURE OF CLERK		52. SIGNATURE OF CLERK		53. SIGNATURE OF CLERK		54. SIGNATURE OF CLERK		55. SIGNATURE OF CLERK		56. SIGNATURE OF CLERK		57. SIGNATURE OF CLERK		58. SIGNATURE OF CLERK		59. SIGNATURE OF CLERK		60. SIGNATURE OF CLERK		61. SIGNATURE OF CLERK		62. SIGNATURE OF CLERK		63. SIGNATURE OF CLERK		64. SIGNATURE OF CLERK		65. SIGNATURE OF CLERK		66. SIGNATURE OF CLERK		67. SIGNATURE OF CLERK		68. SIGNATURE OF CLERK		69. SIGNATURE OF CLERK		70. SIGNATURE OF CLERK		71. SIGNATURE OF CLERK		72. SIGNATURE OF CLERK		73. SIGNATURE OF CLERK		74. SIGNATURE OF CLERK		75. SIGNATURE OF CLERK		76. SIGNATURE OF CLERK		77. SIGNATURE OF CLERK		78. SIGNATURE OF CLERK		79. SIGNATURE OF CLERK		80. SIGNATURE OF CLERK		81. SIGNATURE OF CLERK		82. SIGNATURE OF CLERK		83. SIGNATURE OF CLERK		84. SIGNATURE OF CLERK		85. SIGNATURE OF CLERK		86. SIGNATURE OF CLERK		87. SIGNATURE OF CLERK		88. SIGNATURE OF CLERK		89. SIGNATURE OF CLERK		90. SIGNATURE OF CLERK		91. SIGNATURE OF CLERK		92. SIGNATURE OF CLERK		93. SIGNATURE OF CLERK		94. SIGNATURE OF CLERK		95. SIGNATURE OF CLERK		96. SIGNATURE OF CLERK		97. SIGNATURE OF CLERK		98. SIGNATURE OF CLERK		99. SIGNATURE OF CLERK		100. SIGNATURE OF CLERK	
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RECEIVED  
FEB 11 1955  
BUREAU V. S.

1625

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Quinos Mills</b>		c. LENGTH OF STAY IN 1b <b>22 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Rosewood Stat Training School</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MERYL LUCIEN BLAIR</b> Middle <b>GOLDBERG</b> Last <b>GOLDBERG</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1931</b>
9. AGE (In years last birthday) <b>26 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JULIUS GOLDBERG</b>		14. MOTHER'S MAIDEN NAME <b>ROSALIE DUBIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Chart of Rosewood School</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Pneumonia - bronchial</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malnutrition, Dehydration</b> DUE TO (c) <b>Chronic</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congenital Idiocy -</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1957</b> , to <b>Feb 17, 1958</b> , that I last saw the deceased alive on <b>Feb 17, 1958</b> , and that death occurred at <b>8:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Rosewood Tr. School</b> DATE SIGNED <b>2/17/58</b> ACTUAL SIGNATURE <b>Olive Reid Harris, M.D.</b> PHYSICIAN'S NAME (Type) <b>Olive Reid Harris, M.D.</b> <b>Quinos Mills, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-23-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rosedale</b>		22d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc 3100 Guitaw Pl</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, or the registrar, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 25 1938

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1626

## CERTIFICATE OF DEATH

01605

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>4809 Carmella Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank Henry Good, Jr.</b>		4. DATE OF DEATH <b>February 20, 1958</b>	
5. <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1898</b>
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>	
11. BIRTHPLACE (State or foreign country) <b>Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Frank H. Good, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Emily Armstrong</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>World War I</b>		16. SOCIAL SECURITY NO. <b>161-03-5877</b>	
17. INFORMANT <b>Evelyn C. Good</b>		Address <b>4809 Carmella Dr.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO (b) <b>Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 dys.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>Feb. 17<sup>th</sup></b> , 19 <b>58</b> , to <b>Feb. 20<sup>th</sup></b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 20<sup>th</sup></b> , 19 <b>58</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George H. Frisbey</b> M.D.		ADDRESS (Street, city or town, state) <b>4815 Wilkens Ave. (28)</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>George H. FRISKEY, M.D.</b>		<b>Balto., MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 24, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monterose Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Upper Darby, Penn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE <b>FEB 24 '58</b>		<b>Arthur Smith</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

CERTIFICATE OF DEATH

1958

BALTIMORE		BALTIMORE	
1800 Carmella Drive		1800 Carmella Drive	
Frank E. Gold, Jr.		Frank E. Gold, Jr.	
Male		Male	
White		White	
Married		Married	
Born May 14, 1908		Born May 14, 1908	
U.S.		U.S.	
Residing at home		Residing at home	
Service Corp.		Service Corp.	
Frank E. Gold, Jr.		Frank E. Gold, Jr.	
1800 Carmella Drive		1800 Carmella Drive	
BALTIMORE		BALTIMORE	

BUREAU V. 1

FEB 24 1958

RECEIVED

Burial Feb. 25, 1958, Northern Cemetery, Upper Larch, Penn.  
Howard N. Hubbard, 8107 Wilkens Ave.

1627

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> M		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>42 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>L.</b> Last <b>GREEN</b>		4. DATE OF DEATH Month <b>February</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1895</b>
9. AGE (In years last birthday) yrs. <b>63</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	IF UNDER 24 HRS. Hours <b>0</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Ephriam Green</b>		14. MOTHER'S MAIDEN NAME <b>Mary Schettler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>WW I</b>	
17. INFORMANT <b>Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOGENIC CARCINOMA OF LEFT LOWER LOBE</b> <b>162.1</b> <b>WITH METASTASES TO RIGHT LUNG, PLEURA, LIVER AND</b> <b>XXXXX</b> <b>KIDNEYS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>DUE TO</b> (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 17, 1958</b> to <b>February 28, 1958</b> and that death occurred at <b>11:05 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA Hospital, FORT HOWARD, MARYLAND 2/28/58</b>			
ACTUAL SIGNATURE <b>Chien Wei Ian</b> M.D. <b>VA Hospital, FORT HOWARD, MARYLAND</b>			
PHYSICIAN'S NAME (Type) <b>CHIEN WEI IAN, M.D., VAH, FORT HOWARD, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-4-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. 14, Md.</b>		24. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	

142  
TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, by the funeral director, page should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1628  
Item 9 Film 3225 2-25-58 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01606

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55-TOWSON,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eudowood TOWSON 4, Md.</u>		d. STREET ADDRESS <u>1634 NATURO RD</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Grimes</u> Last <u>Grimes</u>		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1986</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1887</u> AGE (In years last birthday) <u>97</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>night man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>Edward Grimes</u>		14. MOTHER'S MAIDEN NAME <u>Catherine McCarthe</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-14-6090</u>	
17. INFORMANT <u>Personal History</u> Address <u>Hospital Records Eudowood Sanatorium</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Arteriosclerosis, General.</u> DUE TO (c) <u>unk.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Tuberculosis &amp; Thoracoplasty Rt</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/3</u> , 19 <u>86</u> , to <u>2/13</u> , 19 <u>86</u> , that I last saw the deceased alive on <u>2/13</u> , 19 <u>86</u> , and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Eudowood Sanatorium</u> DATE SIGNED <u>Bennett A. Stoen</u>			
ACTUAL SIGNATURE <u>Bennett A. Stoen</u> M.D. <u>Eudowood Sanatorium</u>		PHYSICIAN'S NAME (Type) <u>BENNETT A. STOEN</u> <u>TOWSON 4, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 14, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Preston, Caroline Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u> ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 18 '86</u> 24b. REGISTRAR'S SIGNATURE <u>Reg. Seal</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED J. J. JONES		2. SEX Male		3. AGE 45		4. RACE White		5. BIRTH DATE 1/15/1918		6. BIRTH PLACE Baltimore, Md.	
7. DECEASED DATE 2/18/1958		8. DECEASED TIME 10:00 AM		9. DECEASED PLACE Home		10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED DOCTOR J. J. Jones	
13. DECEASED HUSBAND J. J. Jones		14. DECEASED WIFE J. J. Jones		15. DECEASED CHILDREN J. J. Jones		16. DECEASED SIBLINGS J. J. Jones		17. DECEASED PARENTS J. J. Jones		18. DECEASED GRANDPARENTS J. J. Jones	
19. DECEASED GREAT-GRANDPARENTS J. J. Jones		20. DECEASED GREAT-GRANDSIBLINGS J. J. Jones		21. DECEASED GREAT-GRANDCHILDREN J. J. Jones		22. DECEASED GREAT-GRANDPARENTS J. J. Jones		23. DECEASED GREAT-GRANDSIBLINGS J. J. Jones		24. DECEASED GREAT-GRANDCHILDREN J. J. Jones	

**BUREAU V. 2**  
FEB 18 1958  
**RECEIVED**

25. DECEASED GREAT-GRANDPARENTS J. J. Jones		26. DECEASED GREAT-GRANDSIBLINGS J. J. Jones		27. DECEASED GREAT-GRANDCHILDREN J. J. Jones		28. DECEASED GREAT-GRANDPARENTS J. J. Jones		29. DECEASED GREAT-GRANDSIBLINGS J. J. Jones		30. DECEASED GREAT-GRANDCHILDREN J. J. Jones	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1629

## CERTIFICATE OF DEATH

01607

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Gwynnbrook Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>L.</b> Last <b>Groesèl</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 15, 1878</b>
9. AGE (In years and months) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Akron, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Philip Weber</b>		14. MOTHER'S MAIDEN NAME <b>Mary Deitz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>Arthur H. Brandt</b>		Address <b>Owings Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic C-V Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>2-8-58</b> , 19 <b>58</b> , to <b>2-10-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-10-58</b> , 19 <b>58</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D. D. Caples</b>		ADDRESS (Street, city or town, state) <b>6 Hanover Rd. Reisterstown, Md.</b>	
DATE SIGNED <b>2-10-58</b>			
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 13, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Brooklyn Heights Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cleveland, Ohio</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 11 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. Brandt</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01608

1545

Reg. Dist. No.

**1**  
FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. LENGTH OF STAY IN 1b <u>51</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2924 Charleston Ave.</u>		d. STREET ADDRESS <u>2924 Charleston Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert M. Groves</u> First Middle Last		4. DATE OF DEATH <u>2-10-58</u> Month Day Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-12-1877</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>? Groves</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, no, or unknown</u>		16. SOCIAL SECURITY NO. <u>Geneva M. Coats, 1958 Francis Ave</u>	
17. INFORMANT <u>Geneva M. Coats, 1958 Francis Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Cardiovascular disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) _____	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Feb. 10, 1958</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>	
22b. DATE THEREOF <u>2-13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	
22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>		23. MEDICAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> ADDRESS <u>4107 Wilkens Ave</u>	
24a. REC'D BY REGISTRAR <u>FEB 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND

RECEIVED  
FEB 14 1950  
BUREAU V. S.

HOWARD P. HARRIS, 1107 WILKINS AVE  
BALTIMORE 5-13-50  
LONDON PARK



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1630

## CERTIFICATE OF DEATH

01609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 ESSEX</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>507 FRANKLIN AVE</u>		d. STREET ADDRESS <u>507 FRANKLIN AVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>OTTO FRED GRUND JR</u>		4. DATE OF DEATH Month Day Year <u>2 / 23 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 1 - 1906</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FORT HOLABIRD</u>	
11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>OTTO FRED GRUND</u>		14. MOTHER'S MAIDEN NAME <u>JESSE MACKAI</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-01-4929</u>	
17. INFORMANT <u>MARIE GRUND (WIFE)</u>		Address <u>ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> <u>141.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Tongue &amp;</u> DUE TO (c) <u>Metastases To Neck</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1 Sept. 1</u> , 19 <u>57</u> , to <u>23 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>23 Feb</u> , 19 <u>58</u> , and that death occurred at <u>MD.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>700 N. A. Rodgers</u> DATE SIGNED <u>Wm. A. Rodgers</u>			
ACTUAL SIGNATURE <u>Wm. A. Rodgers</u>		PHYSICIAN'S NAME (Type) <u>Wm. A. Rodgers MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/27/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Connelly</u>		ADDRESS <u>418 Eastern Ave. Balto. 21-Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overland</u>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# STATE OF MARYLAND—BALTIMORE, 18

Item 11, Film G226 3-20-58 et

1631

## CERTIFICATE OF DEATH

Reg. Dist. No.

01610

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard.</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4 Chestnut Ave.</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Gunter</b> Last				4. DATE OF DEATH Month <b>Feb.</b> Day <b>7</b> Year <b>19 58</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 13, 1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>at home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Peter Schultz</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>James E. Gunther</b> Address <b>Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>c Metastases</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardiovascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1958</b> , to <b>Feb. 7, 1958</b> , that I last saw the deceased alive on <b>Feb. 7, 1958</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>914 D Street</b> DATE SIGNED <b>2/7/58</b> ACTUAL SIGNATURE <b>David Owens</b> M.D. PHYSICIAN'S NAME (Type) <b>David Owens, M.D., Balto. 19, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>Feb. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Homes, Dundalk, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead (Rural)</u>	
c. LENGTH OF STAY IN 1b <u>30 yrs</u>		d. STREET ADDRESS <u></u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JACOB - F - HALE</u> First Middle Last		4. DATE OF DEATH <u>Feb 4</u> Month Day Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 30-1865</u> 9. AGE (In years last birthday) <u>92</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>	11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Zachariah Hale</u>		14. MOTHER'S MAIDEN NAME <u>Rachel Hale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Preston Hale - Hampstead Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arterio Sclerosis</u> 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 1957</u> to <u>Feb 4, 1958</u> , that I last saw the deceased alive on <u>Jan 3, 1958</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		DATE SIGNED <u>2-5-58</u>	
PHYSICIAN'S NAME (Type) <u>M.C.P rterfield, M.D.</u>		<u>Hampstead, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 7-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grave Run</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw &amp; Nipton - Hampstead Md</u> ADDRESS		24a. REC'D BY REGISTRAR <u>FEB 10 58</u> DATE	24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1932

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES M. WOOD		45		M		W		1887		BALTIMORE		MD		U.S.A.	
MARRIAGE		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1910		BALTIMORE		MD		U.S.A.		FEB 10 1932		BALTIMORE		MD	
CAUSE OF DEATH		DISEASE		COMPLICATIONS		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH	
HEART DISEASE		CORONARY ARTERY DISEASE		HYPERTENSION		SUICIDE		BALTIMORE		MD		U.S.A.		FEB 10 1932	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. M. WOOD		FEB 10 1932		BALTIMORE		MD		U.S.A.		FEB 10 1932		BALTIMORE		MD	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
J. M. WOOD		FEB 10 1932		BALTIMORE		MD		U.S.A.		FEB 10 1932		BALTIMORE		MD	

BUREAU V. S.

FEB 10 1932

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH - BIRTH - DEATH - CERTIFICATE OF DEATH

1958

WILLIAM BOND

BUREAU V. 1

FEB 24 1958

RECEIVED

1634

CERTIFICATE OF DEATH

01613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Herbert</b> Last <b>Hall</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 31, 1887</b>
9. AGE (In years lost birthday) <b>70 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Delaware</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Hall</b>		14. MOTHER'S MAIDEN NAME <b>Sinah S. Hastings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>213-099-799A</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic pulmonary emphysema.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive failure due to atherosclerotic heart disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 6, 1958</b> , to <b>Feb. 16, 1958</b> , that I last saw the deceased alive on <b>Feb. 12, 1958</b> , and that death occurred at <b>11:45 p. M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-16-58</b>			
ACTUAL SIGNATURE <b>C. Eugene Watermann, M.D.</b>		PHYSICIAN'S NAME (Type) <b>C. Eugene Watermann, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 20, 58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 14, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons</b>		24. REG. BY REGISTRAR <b>CO.</b>	
25. ADDRESS <b>4905 York Road Balto. 12, Md.</b>		26. REGISTRAR'S SIGNATURE <b>CO.</b>	

TO HOSPITAL OR A BOARDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
1931  
CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race	
4. Date of birth		5. Date of death		6. Place of birth	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
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34. Signature of jury		35. Signature of jury		36. Signature of jury	
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79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	

BUREAU V. S.

FEB 21 1931

RECEIVED



1635  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bengies</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bengies</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 9 Bowleys Quarters Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Hanousek</u> Last <u></u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 12, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sporting Goods</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.A</u>	
13. FATHER'S NAME <u>Frank Hanousek</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Hilda A. Hanousek</u>		Address <u>Box 9 Bowleys Quarters Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>ART. SCLER. CORONARY DISEASE</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 MIN</u> <u>2 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Feb 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 5</u> , 19 <u>58</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis Semendoff</u>		ADDRESS (Street, city or town, state) <u>2108 Orem Rd, Balto, Md</u>	
PHYSICIAN'S NAME (Type) <u>LOUIS SEMENDOFF</u>		DATE SIGNED <u>2/6/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 8, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Orem's Methodist</u>	22d. LOCATION (City, town, or county) (State) <u>Stemmers Run Rd. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carroll Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES EARL RAY		Male		35		White		April 14, 1928		Memphis, Tennessee		April 4, 1968		Memphis, Tennessee		Gunshot wound		Homicide		[Signature]		[Signature]	
13. FULL NAME OF PHYSICIAN		14. FULL NAME OF SURGEON		15. FULL NAME OF PATHOLOGIST		16. FULL NAME OF FORENSIC EXAMINER		17. FULL NAME OF MENTAL EXAMINER		18. FULL NAME OF NURSE		19. FULL NAME OF CHAPLAIN		20. FULL NAME OF MINISTER		21. FULL NAME OF OTHER		22. FULL NAME OF OTHER		23. FULL NAME OF OTHER		24. FULL NAME OF OTHER	
[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
25. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		26. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		27. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		28. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		29. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		30. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		31. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		32. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		33. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		34. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.		35. I certify that I am a duly qualified physician, surgeon, pathologist, forensic examiner, mental examiner, nurse, chaplain, minister, or other person authorized to sign this certificate.			

BUREAU V. 5

FEB 7 1968

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1538

## CERTIFICATE OF DEATH

Reg. Dist. No. 01615

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN TB			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3437 McShane Way</b>				d. STREET ADDRESS <b>3437 McShane Way</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen</b> Last <b>Harrington</b>				4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>19 58</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 22, 1887</b>	9. AGE (In years last birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret'd Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Malock Brothers</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew DeMartin</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Hamby</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-09-9547</b>		17. INFORMANT <b>Mrs. H.C. Weinrich, 7537 Ives Lane, Dundalk 22</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insuff</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arterio-sclerotic C.R.D.</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month <b>19</b>	Day <b>19</b>	Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Dundalk 22, Maryland</b>	(County) (State)
21. I certify that I attended the deceased from <b>April 30, 19 57</b> to <b>Feb 27, 19 58</b> that I last saw the deceased alive on <b>Feb 27, 19 58</b> , and that death occurred at <b>10:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Samuel J. Harkins</b> M.D.				DATE SIGNED <b>Mar 4 '58</b>			
PHYSICIAN'S NAME (Type) <b>Samuel J. Harkins</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Dundalk 22, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Harkins</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 4 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01616

Reg. Dist. No.

1636

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>4mths17dys</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Annabell</u> Middle <u>Lee</u> Last <u>Harrison</u>		4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1920</u>
9. AGE (In years last birthday) yrs. <u>37</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fred T. Ray</u>		14. MOTHER'S MAIDEN NAME <u>Hoffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkin's Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 28</u> , 19 <u>58</u> , to <u>2-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>58</u> , and that death occurred at <u>1258</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Augusto Jose Esquivel</u> M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) <u>Augusto Jose Esquivel</u>		<u>Catonsville 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/25/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John T. Stanberry</u>		ADDRESS <u>Woodlawn</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BURKAY V. S.

FEB 24 1958

RECEIVED

BRUNER 2/25/58 London TRK BALTIMORE MD  
J. T. Bruner

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01617

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fork, Rural</b>		c. LENGTH OF STAY IN 1b <b>instant</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Harford Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Sidney Ballard</b>		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Apr. 29, 1930</b>	
9. AGE (In years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>27</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Md.,</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Harvey</b>		14. MOTHER'S MAIDEN NAME <b>Rethie Bonomis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-28-8455</b>	
17. INFORMANT <b>Robert Harvey, Franklinville, Maryland.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rupture of Aorta</b> 819X Conditions, if any, which gave rise to immediate cause (b) <b>Massive hemothorax due to Crushing Injury of Chest</b> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Auto struck bridge abutment</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>11:5 p.m. 2/26 '58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>street</b>		20f. (City or town) (County) (State) <b>Hartley Mill Baltimore Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>William V. Lovitt, Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 2, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Salem</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Falls, Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard R. M. Conner Jr.</i>		24a. REC'D BY REGISTRAR DATE <b>MAR 5 '58</b>	
ADDRESS <b>Abingdon, Md.,</b>		24b. REGISTRAR'S SIGNATURE <i>W. H. Beach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

THE STATE  
HEALTH DEPT.

RECEIVED  
MAR 5 1958  
BUREAU V. 3

1. Name of Deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of Birth: \_\_\_\_\_

5. Place of Birth: \_\_\_\_\_

6. Race: \_\_\_\_\_

7. Occupation: \_\_\_\_\_

8. Cause of Death: \_\_\_\_\_

9. Manner of Death: \_\_\_\_\_

10. Signature of Medical Examiner: \_\_\_\_\_

11. Date of Examination: \_\_\_\_\_

12. Place of Examination: \_\_\_\_\_

13. Name of Hospital: \_\_\_\_\_

14. Name of Physician: \_\_\_\_\_

15. Name of Coroner: \_\_\_\_\_

16. Name of Undertaker: \_\_\_\_\_

17. Name of Burial Place: \_\_\_\_\_

18. Name of Burial Place: \_\_\_\_\_

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1638

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto 14 Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3605 Joppa Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. George Haslbeck</u>		4. DATE OF DEATH <u>February 3rd 19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 12 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clothing Buyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Buyer</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Haslbeck</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Schmidt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-03-1605</u>	
17. INFORMANT <u>Mrs. Isabelle Haslbeck, same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) <u>Rheumatic Fever</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>40 yrs</u> <u>Child</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis &amp; Emphysema</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 3</u> , 19 <u>58</u> , to <u>Feb 3</u> , 19 <u>58</u> , that I lost saw the deceased alive on <u>Feb 3</u> , 19 <u>58</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank J. Kasik Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>9005 Harford Rd BALTO 14 Md</u>	
PHYSICIAN'S NAME (Type) <u>FRANK J. KASIK JR.</u>		DATE SIGNED <u>2/3/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road</u>		24a. REC'D BY REGISTRAR <u>FEB 5 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Albert Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





## Reg. Dist. No.

1630

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Pulaski Highway</b>		d. STREET ADDRESS <b>913 Rosedale Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>GEORGE D. HASWELL</b>		4. DATE OF DEATH Month <b>FEB</b> Day <b>19</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 7, 1899</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Station operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gasoline</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Sian Haswell</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes WWI</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs Annie P. Haswell</b>		Address <b>913 Rosedale Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIO SCLEROTIC HEART DISEASE</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>NOV 1957</b> , to <b>FEB 19, 1958</b> , that I last saw the deceased alive on <b>FEB 18, 1958</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8019 Phila Rd BALTIMORE, MD</b> DATE SIGNED <b>2/2/58</b>			
ACTUAL SIGNATURE <b>Emmett P. Davis</b>		M.D. <b>8019 Phila Rd BALTIMORE, MD</b>	
PHYSICIAN'S NAME (Type) <b>EMMETT P. DAVIS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memo. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Durham N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran 3000 E. Balto. St. Balto.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

VS A1S (4)  
15M 9/SS

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased John A. Woodley		Date of Death 2/28/38		Place of Death Baltimore	
Age 50		Sex Male		Race White	
Date of Birth 2/28/1888		Place of Birth North Carolina		Usual Residence 918 Rosedale Ave., Baltimore	
Cause of Death Unknown		Manner of Death Natural		Signature of Physician D. MacNeill	
Name of Informant Mrs. Annie P. Newell		Address of Informant 918 Rosedale Ave., Baltimore		Signature of Informant [Signature]	
Name of Registrar [Signature]		Signature of Registrar [Signature]		Date of Registration 2/28/38	
Name of Burial Place [Signature]		Signature of Burial Place [Signature]		Date of Burial 2/28/38	

RECEIVED  
FEB 28 1938  
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01620

1640

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				d. STREET ADDRESS <b>530 W. Saratoga St.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First <b>NMI</b>		Middle <b>HATTEN</b>		Last	
4. DATE OF DEATH <b>FEBRUARY</b>		Month <b>2</b>		Day <b>19</b>		Year <b>58</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 20, 1882</b>	
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Greenville, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Hatten</b>				14. MOTHER'S MAIDEN NAME <b>Vinie Boyd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213-09-0414</b>		17. INFORMANT Address <b>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>434.3</b> IMMEDIATE CAUSE (a) <b>FIBRINOUS PERICARDITIS</b> DUE TO (b) <b>LOBULAR PNEUMONIA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b> <b>HYPERTENSIVE CARDIOMEGALY</b>							INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>  <b>unknown</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 9th</b> , 19 <b>58</b> to <b>Feb. 2nd</b> , 19 <b>58</b> and that death occurred at <b>9:15 AM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Donald D. Mark</b>				ADDRESS (Street, city or town, state) <b>VAM Fort Howard, Maryland</b>		DATE SIGNED <b>2/2/58</b>	
PHYSICIAN'S NAME (Type) <b>Donald D. Mark, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law - 802 Madison Ave.</b>				24a. REC'D BY REGISTRAR <b>FEB 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

Charles R. Law 802 Madison Ave., Baltimore-1, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

RECEIVED

FEB 4 1953

TABLEAU N. 1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1641

## CERTIFICATE OF DEATH

01621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle Last <b>Hegeman</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Unknown</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Unknown</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atherosclerotic Cardio-vascular disease</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1954</b> , to <b>Feb. 17, 1958</b> , that I last saw the deceased alive on <b>Feb. 17, 1958</b> , and that death occurred at <b>6:40 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>C. Eugene Watermann</b> M.D.				ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-17-58</b>			
PHYSICIAN'S NAME (Type) <b>C. Eugene Watermann, M. D.</b>				Catonsville 28, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>2-21-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Bethesda</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. McCully</b> <i>Per John Shunk</i>				ADDRESS <b>130 E. Port Ave.</b>		24a. REC'D BY REGISTRAR <b>Feb 20 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>Aw. Branch</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registry prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1933

SEE THIS SIDE

BUREAU V. S.

FEB 20 1933

RECEIVED

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1642

## CERTIFICATE OF DEATH

Reg. Dist. No.

01622

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>9</b> b. COUNTY <b>Balto. Md. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN 1b <b>15yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marguerite G.</b> Middle <b>Heinecke</b> Last		4. DATE OF DEATH Month <b>Feb. 13, 1958</b> Day <b>19</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 15, 1911</b>
9. AGE (In years last birthday) yrs. <b>46</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Office</b>	
11. BIRTHPLACE (State or foreign country) <b>Kaiser W. Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Arthur Charlton</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Boswell</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Walter E. Heinecke, 9 Bauernschmidt Manor 21</b>		Address <b>Middle River</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Lymphosarcoma</b> 200.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> , 19____, to <b>1958</b> , that I last saw the deceased alive on <b>Feb 12</b> , 19 <b>58</b> , and that death occurred at <b>9:10</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Harry Gilbert</b>		ADDRESS (Street, city or town, state) <b>6006 Eastern av Balt 24 Md</b>	
PHYSICIAN'S NAME (Type) <b>HARRY GILBERT</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 15, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>M Olivet Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Moorefield W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Henry Law</b>		24a. REC'D BY REGISTRAR <b>2024 Orleans Street 31</b>	
24b. REGISTRAR'S SIGNATURE <b>Feb 18 58</b>		DATE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 18 1958

BUREAU V. 4

HARRY GIRBERT

Harry Gilbert

1958

Terminal Improvement

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1546

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Halethorpe</u>	
c. LENGTH OF STAY IN lb <u>1 Hr.</u>		d. STREET ADDRESS <u>5513 Willys Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5203 Leeds Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen May Hemp</u>		4. DATE OF DEATH Month Day Year <u>FEB. 25, 1958</u>	
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1887</u>
9. AGE (In years and month) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert Dawson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Shipley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>218-20-1157 A</u>	
17. INFORMANT <u>Easton Sons. Funeral Home. Catonsville Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cardiovascular disease</u> (c) <u>Cardiovascular disease</u> DUE TO (c) <u>Cardiovascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>		DATE SIGNED <u>Feb. 25, 1958</u>	
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/28/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons</u>		24a. REC'D BY REGISTRAR <u>Feb 28 '58</u>	
ADDRESS <u>Catonsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 28 1953

BUREAU V. S.

FOR STATE  
HEALTH DEPT

RECEIVED



1643

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Conval. Home-Bosley Ave.</b>		1 d. STREET ADDRESS <b>7109 York Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>H.</b> Last <b>HEMPEL</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>26,</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 15, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Otto Warner</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmina Stafort</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>	
17. INFORMANT <b>Mrs. Wm. F. Chew - Owings Mills, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio Vascular Disease</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Atherosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 15, 1957</b> , to <b>Feb. 26, 1958</b> , that I last saw the deceased alive on <b>Feb. 26, 1958</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Laurence C. Post</b> M.D.		<b>6805 York Rd. Baltimore 12 Md.</b>	
PHYSICIAN'S NAME (Type) <b>LAURENCE C. Post</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/28/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Sicker</b>		24a. REC'D BY REGISTRAR <b>Wm. F. Sicker</b>	24b. REGISTRAR'S SIGNATURE <b>Wm. F. Sicker</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1644

## CERTIFICATE OF DEATH

01625

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		c. LENGTH OF STAY IN 1b <u>52 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9 Walnut Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>A.</u> Last <u>Heuisler</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>15</u> Year <u>58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aloysius Krichton</u>		14. MOTHER'S MAIDEN NAME <u>Anastasia Barringer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mrs. Anna Bermel</u>		Address <u>9 Walnut Ave. (6)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u> 443X DUE TO (b) <u>Cardio-Vascular Hypertensive Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>7 years</u> <u>7 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 24, 1951</u> to <u>Feb 15, 1958</u> , that I last saw the deceased alive on <u>Feb 15, 1958</u> , and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Michael J. Dausch</u> M.D.		ADDRESS (Street, city or town, state) <u>4636 Belair Road</u> DATE SIGNED <u>2/18/58</u>	
PHYSICIAN'S NAME (Type) <u>Michael J. Dausch</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 19, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
24a. REC'D BY REGISTRAR <u>FEB 20 58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director, by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01626

1645

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>"Overlook" Sheppard-Pratt Hosp.</b>			
3. NAME OF DECEASED (Type or print) <b>Lewis Brown</b>		4. DATE OF DEATH <b>February 4 1958</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 18, 1894</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Psychiatrist-in-Chief</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>	
13. FATHER'S NAME <b>Elmer Hill</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Agatur</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		17. INFORMANT <b>Mrs. Reba Z. Hill - Overlook. Towson 1, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 480.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Sudden</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles F. O'Donnell</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/5/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/6/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Dickman &amp; Sons - Baeto</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 7 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Overlook</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

FEB 7 1958

BUREAU V. S.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
1648 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01627

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 TOWSON</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7 ENSOR AVE</u>				d. STREET ADDRESS <u>7 ENSOR AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>VIOLA</u> First Middle Last <u>Hinton</u>				4. DATE OF DEATH <u>February 5</u> 19 <u>58</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u> <u>1882</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOMESTIC</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Private Families</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Francis Hinton</u> Address <u>7 ENSOR AVE, TOWSON, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>174X Metastatic Carcinoma</u> DUE TO (b) <u>Carcinoma of Uterus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>2 Months</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT REST</u>		22d. LOCATION (City, town, or county) (State) <u>TOWSON BALTO CO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. L. Chaturvedi</u> ADDRESS <u>1701 Mt. Calvert St. Balt. Md.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Chaturvedi</u>	

MEDICAL CERTIFICATION

STATE OF  
DEATH

1640  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
STATE OF MARYLAND DEPARTMENT OF HEALTH BALTIMORE 19

RECEIVED  
FEB 10 1958  
BUREAU V. S.

1647

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Balt</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Balt</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Balt</u>	
c. LENGTH OF STAY IN 1b <u>50 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2812 Georgia Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EFFIE</u> First <u>ALTHEA</u> Middle <u>HOFFMAN</u> Last		4. DATE OF DEATH <u>February 12</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>25 Feb 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John McKittrick</u>		14. MOTHER'S MAIDEN NAME <u>Rose Cawley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	
17. INFORMANT <u>son - John Hoffman</u>		Address <u>2812 Georgia Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Cerebrovascular Hemorrhage -</u> DUE TO (b) <u>Arteriosclerosis + hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>year</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1950</u> , to <u>11 Feb 1958</u> , that I last saw the deceased alive on <u>11 Feb 1958</u> , and that death occurred at <u>101208</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Goodman</u> M.D.		ADDRESS (Street, city or town, state) <u>1334 Sulphur Spring</u> DATE SIGNED <u>12 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>WILLIAM GOODMAN, M.D.</u>		<u>Balt, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 15, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Sander &amp; Sons, Inc</u>		ADDRESS <u>Baltimore Md.</u>	
24a. REC'D BY REGISTRAR <u>FEB 14 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 6227 3-42-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 01629

1648

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgemere</b>				c. LENGTH OF STAY IN 1b <b>10 Mos.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Morelands Nursing Home</b>				e. STREET ADDRESS <b>3103 Juneau Place</b>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Holmdahl</b> Last <b>Holmdahl</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>16</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 18, 1870</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min.		IF UNDER 24 HRS. Months <b>87</b> Days <b>87</b> Hours <b>87</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Johanson</b>				14. MOTHER'S MAIDEN NAME <b>-</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Mrs Esther Keenan 9 Sipple Ave.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Ht. Disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>-</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>4 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1957</b> , to <b>Feb. 16, 1958</b> , that I last saw the deceased alive on <b>Feb. 16, 1958</b> , and that death occurred at <b>7 A.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James T. Means</b>				ADDRESS (Street, city or town, state) <b>5701 St. Balto Md</b>			
PHYSICIAN'S NAME (Type) <b>James T. Means</b>				DATE SIGNED <b>2-18/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/19/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Tickner &amp; Son. North &amp; Penna. Aves. Balto. Md.</b>				24a. REC'D BY REGISTRAR <b>2-24-58</b>			
24b. REGISTRAR'S SIGNATURE <b>Deedrich</b>							

MEDICAL CERTIFICATION



1649

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH <b>Rosewood State Training School</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)			
a. COUNTY <b>Baltimore</b>		MARYLAND		a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		c. LENGTH OF STAY IN 1b <b>11 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland, Maryland</b> <i>018-2</i> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rosewood State Training School</b>				d. STREET ADDRESS <b>RFD # 5, Box 450 Braddock Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Winter</b> Last <b>Hopwood</b>				4. DATE OF DEATH Month <b>2</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/25/54</b>	
9. AGE (In years last birthday) <b>3</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.		IF UNDER 24 HRS. Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
						12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Kenneth S. Hopwood</b>				14. MOTHER'S MAIDEN NAME <b>Dolores Riggs Hopwood</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Rosewood Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypostatic pneumonia</b> <b>344.2</b> DUE TO <b>Dehydration and malnutrition due to most severe internal hydrocephaly</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } DUE TO <b>Gargoylism ?</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED <b>White</b> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>7:50p M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Rich. Lindenb. M.D.</b>				ADDRESS (Street, city or town, state) <b>708 Hick Street Balto 2</b> DATE SIGNED <b>2/3/58</b>			
PHYSICIAN'S NAME (Type) <b>Richard Lindenberg</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>FEB 6 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

BUREAU V. M.

1958 6 FEB

RECEIVED

1650

## CERTIFICATE OF DEATH

01631

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Randallstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Milford Gardens</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Sheraton Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>A.</b> Last <b>HORAN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>19</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 7, 1899</b>
9. AGE (In years last birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR: Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Heline</b>		14. MOTHER'S MAIDEN NAME <b>Annie ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Mr. Marion M. Horan - 3513 Mayfair Rd.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Sarbanary E. derma</b> <b>170X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Anaemia, Ascites Co. of liver metastases</b> (c) <b>Cancer of breast</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension Cardio Vascular Disease</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>19 58</b> , to <b>19 58</b> , that I last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Louis Dalmau</b>		DATE SIGNED <b>Pikesville, Md. 2/20/58</b>	
PHYSICIAN'S NAME (Type) <b>Louis Dalmau</b>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/22/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Pickner &amp; Sons - Balt. 17th</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Pickner</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3, and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1933

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES V. ...		...		...		...		...		...		...		...	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF INTERMENT		PLACE OF INTERMENT		CITY OF INTERMENT	
FEB 24 1933		...		...		...		...		...		...		...	
CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ORGAN OR PART AFFECTED		CHARACTER OF INJURY		LOCALITY OF INJURY		DATE OF INJURY		PLACE OF INJURY	
...		...		...		...		...		...		...		...	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL SOCIETY		SIGNATURE OF CHURCH		SIGNATURE OF OTHER	
...		...		...		...		...		...		...		...	

BUREAU V. 3

FEB 24 1933

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1651

## CERTIFICATE OF DEATH

01632

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN 1b <b>17yr8mths10dys</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena, Maryland</b> <b>02x-2</b>		
			d. STREET ADDRESS <b>Longhill, Pasadena, Md.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Emily</b> Middle <b>Mary</b> Last <b>Hostler</b>			4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 58</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 9, 1869</b>		9. AGE (In years last birthday) yrs. <b>88</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>England</b>
13. FATHER'S NAME <b>Charles Vicary</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis, severe</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>Feb. 11, 19 58</b> , to <b>Feb. 11, 19 58</b> , that I last saw the deceased alive on <b>Feb. 11, 19 58</b> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____					
ACTUAL SIGNATURE <b>Stella Wachslor</b>		M.D. <b>SPRING GROVE STATE HOSPITAL 2-11-58</b>			
PHYSICIAN'S NAME (Type) <b>Stella Wachslor, M. D.</b>		<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-13-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>5829 Ritchie Hghwy, Balto 25</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>			24a. REC'D BY REGISTRAR <b>FEB 14 '58</b>		
			24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

BUREAU V. S.

FEB 14 1953

RECEIVED

1652

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3224 Putty Hill Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Mrs. Ellen M. (Nellie) Hubbard</i>		4. DATE OF DEATH Month Day Year <i>February 19 19 58</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 25, 1880</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Jerome Murphy</i>		14. MOTHER'S MAIDEN NAME <i>Mary O'Neil</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. George W. Hubbard, Sr.</i>		Address <i>same</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442 X Congestive Heart Failure</i> DUE TO (b) <i>Hypertensive Cardis renal Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <i>Senility</i> DUE TO (c) <i>Senility</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. — 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1946</i> , 19 <i>2/19</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>2/9</i> , 19 <i>58</i> , and that death occurred at <i>7 A.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. White</i>		ADDRESS (Street, city or town, state) <i>5214 Harford Rd.</i>	
PHYSICIAN'S NAME (Type) <i>JAMES E. White MD.</i>		DATE SIGNED <i>2/20/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/22/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>FEB 24 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

FEB 24 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1653

## CERTIFICATE OF DEATH

Reg. Dist. No.

01634

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>903 Sedgley Road</b>				d. STREET ADDRESS <b>903 Sedgley Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARIE HUNTER</b>				4. DATE OF DEATH Month Day Year <b>February 7 19 58</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 20, 1901</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York City</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Adolph Misicka</b>				14. MOTHER'S MAIDEN NAME <b>Frances Meduna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Miss Misicka</b>		Address <b>903 Sedgley Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardinoma of uterus</b> <b>174X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>metastasis to lung</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>2 mos.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 8, 19 58</b> , to <b>Feb. 7, 19 58</b> , that I last saw the deceased alive on <b>Feb. 7, 19 58</b> , and that death occurred at <b>3.30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>203 Ingleside Ave., Baltimore 28, Md.</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>R. M. Hening</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. R. M. Hening</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/10/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's</b>		22d. LOCATION (City, town, or county) (State) <b>Astoria, L.I., New York</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>				ADDRESS <b>1217 St. Paul St., Balto.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the following information: (1) Name of the deceased, (2) Date of death, (3) Place of death, (4) Usual residence, (5) Cause of death, (6) Date of birth, (7) Sex, (8) Color or race, (9) Marital status, (10) Usual occupation, (11) Birthplace, (12) Citizen of what country, (13) Father's name, (14) Mother's maiden name, (15) Was deceased ever in U. S. Armed Forces, (16) Social Security No., (17) Informant, (18) Cause of death, (19) Time of injury, (20) Place of injury, (21) I certify that I attended the deceased from \_\_\_\_\_, 19 \_\_, to \_\_\_\_\_, 19 \_\_, that I last saw the deceased alive on \_\_\_\_\_, 19 \_\_, and that death occurred at \_\_\_\_\_ PM, from the causes and on the date stated above. (22) Burial, cremation, removal, (23) Funeral director's signature, (24) Registrar's signature. After this certificate has been signed by the attending physician and completely filled in by the funeral director, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the following information: (1) Name of the deceased, (2) Date of death, (3) Place of death, (4) Usual residence, (5) Cause of death, (6) Date of birth, (7) Sex, (8) Color or race, (9) Marital status, (10) Usual occupation, (11) Birthplace, (12) Citizen of what country, (13) Father's name, (14) Mother's maiden name, (15) Was deceased ever in U. S. Armed Forces, (16) Social Security No., (17) Informant, (18) Cause of death, (19) Time of injury, (20) Place of injury, (21) I certify that I attended the deceased from \_\_\_\_\_, 19 \_\_, to \_\_\_\_\_, 19 \_\_, that I last saw the deceased alive on \_\_\_\_\_, 19 \_\_, and that death occurred at \_\_\_\_\_ PM, from the causes and on the date stated above. (22) Burial, cremation, removal, (23) Funeral director's signature, (24) Registrar's signature.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01635

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Ann Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN lb <b>15 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSP.</b>		d. STREET ADDRESS <b>County Alms House</b>	
3. NAME OF DECEASED (Type or print) <b>ROBERT HUNTER</b>		4. DATE OF DEATH <b>FEB 1 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/28/76</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMATION <b>Spring Grove Hospital, Record</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO (b) <b>Cardiovascular renal disease</b> DUE TO (c) <b>disease</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo S M Kieffer</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Geo S M Kieffer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>July 1. 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>1300 2nd Suburban Rd</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Finken</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '58</b>	
ADDRESS <b>1318 Light</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE  
DEPT.

BUREAU V. S.

FEB 10 1953

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1655

## CERTIFICATE OF DEATH

01636

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mths23dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Barry</b> Last <b>Hughes</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 11, 1888</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John E. Hughes</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>1913-20</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 24, 1958</b> to <b>Feb. 4, 1958</b> , that I last saw the deceased alive on <b>Feb. 4, 1958</b> , and that death occurred at <b>10:15a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		DATE SIGNED <b>2-4-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Glenn Haven</b>		22d. LOCATION (City, town, or county) (State) <b>A.A.C. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thyrt Fleming</b>		24. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	
ADDRESS <b>Light St.</b>		DATE <b>FEB 6 1958</b>	

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CREMATION PLACE		SIGNATURE OF OTHER	

BUREAU V. S.

EB 6 1933

RECEIVED

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 1 should be detached for use as the burial-transit permit. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1656

## CERTIFICATE OF DEATH

01637

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN TB <b>1yr8dys</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1715 Spence Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Imfang</b> Last <b>Imfang</b>		4. DATE OF DEATH Month <b>2</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>unknown</b>
9. AGE (In years last birthday) <b>3-1-1875</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown-Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>214-01-4019</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 3</b> , 19 <b>57</b> , to <b>Feb 4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 4</b> , 19 <b>58</b> , and that death occurred at <b>1:27</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Augusto Jose Esquivel</b> M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) <b>Augusto Jose Esquivel</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-7-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>	22d. LOCATION (City, town, or county) (State) <b>Ritchie Hgy</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Toulson</b>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1657

## CERTIFICATE OF DEATH

01638

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Bach.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2711 Geartner Road</u>		d. STREET ADDRESS <u>2711 Geartner Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ESTHER - JACOBS</u>		4. DATE OF DEATH Month Day Year <u>FEB 23, 1958</u> 19	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>80</u> yrs.
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SIMON DIENER</u>		14. MOTHER'S MAIDEN NAME <u>TOBA</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Sadie Goldman</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.0</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1, 1954</u> to <u>Feb 23, 1958</u> , that I last saw the deceased alive on <u>Feb 23, 1958</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Manuel Levin</u>		DATE SIGNED <u>4818 Reisterstown Road</u>	
PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN, M.D.</u>		<u>Baltimore Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>FEB 24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>AITZ CHAIM CONG</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>SOI LEVINSON - BROS</u>		ADDRESS <u>1124-26 W. NORTH AVE</u>	
24a. REC'D BY REGISTRAR <u>FEB 25 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 25 1959

RECEIVED

BUREAU V. S.

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 18



1658

## CERTIFICATE OF DEATH

01639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>5205 OLD FREDERICK RD.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALFRED W. JESCHKE</u>		4. DATE OF DEATH Month Day Year <u>FEB. 5. 1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 27, 1867</u>
9. AGE (In years last birthday) yrs. <u>90</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MECHANIC, CHARLES ZIES &amp; SONS</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GERMANY</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CARL E. JESCHKE</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MR. CURT A. H. JESCHKE</u> Address <u>5205 OLD FREDERICK RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CECEMID - DEHYDRATION - 422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANTERIOR WALL MYOCARDIAL INFARCTION</u> DUE TO (c) <u>CARDIOVASCULAR DISEASE</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/1</u> , 19 <u>55</u> , to <u>2/5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>58</u> , and that death occurred at <u>7:20</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>John H. Shaw</u> M.D.		ADDRESS <u>5500 EDMONDSON AVE</u>	
PHYSICIAN'S NAME (Type) <u>JOHN H. SHAW</u>		ADDRESS <u>BALTO. MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>	22b. DATE THEREOF <u>FEB. 6/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIR.</u> ADDRESS <u>4101 EDMONDSON AVE</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1659

## CERTIFICATE OF DEATH

01640

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY IN TB <u>9 mos.</u>		d. STREET ADDRESS <u>3322 Leighton Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Rosewood State Training School</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Antoinette</u> Middle <u>Johnson</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>10</u> Year <u>19 58</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19, 1940</u>
9. AGE (In years last birthday) <u>17 yrs.</u>		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hospital Patient</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Maryland</u>	
13. FATHER'S NAME <u>Clifton Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Lillian Stubbs</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Hospital Records - Rosewood State Tr. School</u>	
17. INFORMANT <u>Hospital Records - Rosewood State Tr. School</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> DUE TO <u>085.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Measles</u> DUE TO (c) <u>Chronic Brain Syndrome cSpastic Paraplegia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome cSpastic Paraplegia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-10-57</u> 19 <u>57</u> to <u>2-10</u> 19 <u>58</u> at I last saw the deceased alive on <u>2-10</u> 19 <u>58</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Viola B. Johns M.D.</u>		ADDRESS (Street, city or town, state) <u>M.D. Rosewood St Tr School</u>	
PHYSICIAN'S NAME (Type) <u>Viola B. Johns, M.D.</u>		DATE SIGNED <u>7/10/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-12-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Catholic Mon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel W. Sullivan Jr - Balto. Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled out, the funeral director should be notified. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 13 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1660

Items 8,9 Film G226 2-28-58 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 01641

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WINGS Mill, MD.</u>		c. LENGTH OF STAY IN IB <u>16 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROSEWOOD STATE TRAINING SCHOOL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA BESSIE JONES</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 15 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 13, 1915</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>WATSON H. JONES</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE E. WAUDBY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>ROSEWOOD RECORDS</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOWER NEPHRON NEPHROSIS</u> DUE TO (b) <u>ELECTROLYTE IMBALANCE</u> DUE TO (c) <u>ACIDOSIS MALNUTRITION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SPASTIC QUADRIPLEGIA, APHASIA</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 30, 1958</u> , to <u>Feb. 15, 1958</u> , that I last saw the deceased alive on <u>Feb. 15, 1958</u> , and that death occurred at <u>9:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest I. Decko</u>		ADDRESS (Street, city or town, state) <u>Rosewood Lane, 6 wings mill, Md.</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST I. DECKO</u>		DATE SIGNED <u>2/15/1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/19/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>COLGATE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ULURICH FUNERAL HOME BUNDUCK MD</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

FEB 24 1958

BUREAU Y. 3

# 1 3 14 1 VS A15 (4) 15M 10/57 TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the page could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the regular prior to burial, cremation, or removal, and in any event within 72 hours after death. 1661 Item 9 Film G226 2-28-58 et 01642 Reg. Dist. No. 1. PLACE OF DEATH a. COUNTY *Baltimore* MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Catonsville* c. LENGTH OF STAY IN 1b *1 yr 7 mo 13 d.* d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION *Spring Grove State Hospital* 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE *Maryland* b. COUNTY *Baltimore* c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) *Baltimore* d. STREET ADDRESS *5016 Norwood Ave.* e. IS RESIDENCE ON A FARM? YES ☐ NO ☐ 3. NAME OF DECEASED (Type or print) First Middle Last *J. Curtis Joyce* 4. DATE OF DEATH Month Day Year *Feb. 15 1958* 5. SEX *m* 6. COLOR OR RACE *w* 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 8. DATE OF BIRTH *April 12 1888* 9. AGE (In years last birthday) *69* yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *Salesman* 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) *New York - U.S.A.* 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME *James L. Joyce* 14. MOTHER'S MAIDEN NAME *Anna Stebbins* 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) *yes* (If yes, give war or dates of service) *World War I* 16. SOCIAL SECURITY NO. *219-20-8714 B* 17. INFORMANT *Blanche Joyce - 5016 Norwood Ave.* 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) *Cerebrovascular accident* 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) *Generalized arteriosclerosis* DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. *19* 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from *July 2 1956*, to *Feb. 15 1958*, that I last saw the deceased alive on *Feb. 15 1958*, and that death occurred at *9:30 p.m.* from the causes and on the date stated above. ADDRESS (Street, city or town, state) *Spring Grove State Hosp. Catonsville, Md* DATE SIGNED *28* ACTUAL SIGNATURE *Isadore Turk* M.D. *Isadore Turk, M.D.* PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION, REMOVAL (Specify) *Burial* 22b. DATE THEREOF *2/20/1958* 22c. NAME OF CEMETERY OR CREMATORY *Greenmount Cemetery* 22d. LOCATION (City, town, or county) (State) *Baltimore Maryland* 23. FUNERAL DIRECTOR'S SIGNATURE *Ellsworth Armacost* ADDRESS *4600 Liberty Hgts. Ave.* 24a. REC'D BY REGISTRAR *FEB 20 58* 24b. REGISTRAR'S SIGNATURE *Armacost*

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. 1

FEB 20 1938

RECEIVED

1547

CERTIFICATE OF DEATH

01643

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Lansdowne</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>2111 Alletta Avenue</u>		d. STREET ADDRESS <u>1 2111 Alletta Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Miss Mabel Keagle</u>		4. DATE OF DEATH Month Day Year <u>February 14th 19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Keagle</u>		14. MOTHER'S MAIDEN NAME <u>Mabel F. Meek</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. Marvin Keagle, 2111 Alletta Avenue</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage c/ft. hypertension</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>10 yrs?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 31, 19 53</u> to <u>Feb. 14, 19 58</u> , that I last saw the deceased alive on <u>Feb. 8, 19 58</u> , and that death occurred at <u>4:00 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>C. Arthur Rossberg</u> M.D.		ADDRESS (Street, city or town, state) <u>2436 Washington Blvd.</u> DATE SIGNED <u>2/14/58</u>	
PHYSICIAN'S NAME (Type) <u>C. ARTHUR ROSSBERG M.D.</u>		<u>Baltimore, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/17/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road.</u>		24a. REC'D BY REGISTRAR <u>FEB 18 '58</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

BUREAU V. 21

FEB 18 1958

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1662

## CERTIFICATE OF DEATH

Reg. Dist. No. 1644

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The House in the Pines 16 Fusting Avenue</b>		d. STREET ADDRESS <b>Jefferson Street</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM J. KELLY</b>		4. DATE OF DEATH <b>2 6 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>November 16, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR <b>2</b> Months <b>6</b> Days <b>19</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman of Elec. Const.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>(unknown) Kelly</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Ferdinand P. Kelly</b>		Address <b>10 West 23rd Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO (b) <b>Arteriosclerotic Cardio-Vascular Disease</b> DUE TO (c) <b>1030</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-4-1957</b> to <b>2-6-1958</b> , that I last saw the deceased alive on <b>2-6-1958</b> , and that death occurred at <b>11:25 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wilmer K. Gallagher</b>		DATE SIGNED <b>2/6/58</b>	
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gallagher</b>		<b>Catonsville 28, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		ADDRESS <b>Baltimore</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES EARL RAY		MALE		35		JAN 19 1928		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		HAIR		EYES	
COUNSELOR		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		BROWN		BLUE	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS		TREATMENT		POSTMORTEM	
FEB 10 1968		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF CLERK		SIGNATURE OF REGISTRAR		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		PLACE		CAUSE		MANNER		DISEASE		SYMPTOMS		TREATMENT		POSTMORTEM	
FEB 10 1968		BALTIMORE		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		PAIN IN CHEST		NO		NO	

RECEIVED  
FEB 10 1968  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, this page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 663 CERTIFICATE OF DEATH

Reg. Dist. No.

01645

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b> c. LENGTH OF STAY IN 1b <b>1 Yr. 3 Mos. 1 Day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Sheppard &amp; Enoch Pratt Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Pittsburgh</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>75x-3</b> d. STREET ADDRESS <b>515 S. Aiken Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Bert</b> Middle <b>Alcorn</b> Last <b>Kerr</b>				4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 58</b>											
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 10, 1872</b>		9. AGE (In years last birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b>		11. IF UNDER 24 HRS. Hours <b>1</b> Min. <b>1</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Engineering</b>				11. BIRTHPLACE (State or foreign country) <b>Iowa</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William Kerr</b>				14. MOTHER'S MAIDEN NAME <b>Mae Alcorn</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>(If yes, give war or dates of service)</b>				17. INFORMANT <b>Hospital Records</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho pneumonia</b> <b>152.7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the Jejunum - Metast.</b> DUE TO (c) <b>Chk.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b> <b>Senile Psychosis</b>												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 14, 1956</b> , to <b>Feb 5, 1958</b> , that I last saw the deceased alive on <b>Feb 5, 1958</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above.															
ACTUAL SIGNATURE <b>W.W. Elgin</b>				ADDRESS (Street, city or town, state) <b>Sheppard Pratt Hosp. Feb 6, 1958</b>				DATE SIGNED <b>Feb 6, 1958</b>							
PHYSICIAN'S NAME (Type) <b>W.W. Elgin</b>				Towson - 4, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Reburied</b>				22b. DATE THEREOF <b>2/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Homewood Cem.</b>		22d. LOCATION (City, town, or county) <b>Pittsburgh, Pa.</b>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS - Balto. 17 Md.</b>				ADDRESS <b>BALTO. 17 MD.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 10 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Tickner</b>					

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01646

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore County</b> <b>4</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN lb <b>12 month</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b> <b>0210-2</b>	
d. STREET ADDRESS <b>109, MAIN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>LEE</b> Middle <b>KIM</b> Last <b>LEE</b>		4. DATE OF DEATH Month <b>2</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>CHINESE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/28/81</b>
9. AGE (In years last birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>6</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAUNDRY MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CHINA</b>	
11. BIRTHPLACE (State or foreign country) <b>CHINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>CHINA</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>		14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Address <b>Hospital Records, Mt. Wilson State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>7 days</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>002X PULMONARY TUBERCULOSIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1-9-</b> 19 <b>57</b> to <b>2-6-</b> 19 <b>58</b> , that I last saw the deceased alive on <b>2-5-</b> 19 <b>58</b> , and that death occurred at <b>7:25</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED <b>William Newcomer</b>			
ACTUAL SIGNATURE <b>William Newcomer</b> M.D.		DATE SIGNED <b>William Newcomer</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2-9-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Leo Wash. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. M. Lee</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alb...</b>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1668

## CERTIFICATE OF DEATH

01647

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2704 Wildberger Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Louis</b> Middle <b>O.</b> Last <b>Kindervater</b>				4. DATE OF DEATH Month <b>February</b> Day <b>17th</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 15, 1893</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clothing cutter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Kindervater</b>				14. MOTHER'S MAIDEN NAME <b>Wilhelmina Kuehne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>215-05-6580</b>		17. INFORMANT Address <b>Mrs. Georgianna Kindervater, same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis.</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>54</b> , to <b>Feb 17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 14</b> , 19 <b>58</b> , and that death occurred at <b>10:00</b> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harold H Burns</b>				DATE SIGNED <b>Feb 17, 1958</b>			
PHYSICIAN'S NAME (Type) <b>Harold H. Burns.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Road #14</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Quel...</b>			

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>1666</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in the Pines (Home)</b>		d. STREET ADDRESS <b>3 Bishop Lane</b>	
3. NAME OF DECEASED (Type or print) <b>William McNair Kittredge</b>		4. DATE OF DEATH <b>Feb. 17, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1877</b>
9. AGE (In years last birthday) <b>81 yrs.</b>		IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Presbyterian Minister</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pastor of Churches</b>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joshia E. Kittredge</b>		14. MOTHER'S MAIDEN NAME <b>Emma McNair</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>074-28-0387</b>	
17. INFORMANT <b>Mr. W. M. Kittredge</b>		Address <b>1117 Gary Drive Catons. 28</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b> <b>1 yr +</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>February 4, 1958</b> , to <b>Feb. 17, 1958</b> , that I last saw the deceased alive on <b>Feb. 15, 1958</b> , and that death occurred at <b>1:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John A. Nesbitt Jr.</b>		ADDRESS (Street, city or town, state) <b>1118 St. Paul St.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN A. NESBITT JR.</b>		DATE SIGNED <b>2-17-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/18/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Crown Hill Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>New Hartford, N. Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Easton Sons</b>		ADDRESS <b>Catonsville, Md.</b>	
24a. REC'D BY REGISTRAR <b>Feb 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Ch. [Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

THE STATE OF

1908

DEATH

HABIT

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

RELIGION

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PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

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DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

AGE

SEX

EDUCATION

OCCUPATION

BUREAU V. S.

FEB 21 1908

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1667

## CERTIFICATE OF DEATH

01649

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>6yr3mth10dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>6504 "E" Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Harriet</b> Middle <b>E.</b> Last <b>Knauer</b>		4. DATE OF DEATH Month <b>2</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>saleswoman</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Jetter</b>		14. MOTHER'S MAIDEN NAME <b>Sara</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <b>Arteriosclerosis is</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from <b>Feb. 4, 1958</b> , to <b>Feb. 8, 1958</b> , that I last saw the deceased alive on <b>Feb. 8, 1958</b> , and that death occurred at <b>9:20 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Bruno Radauskas</b> M.D.		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>	
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUSKAS</b>		DATE SIGNED <b>2/8/1958</b>	
22a. BURIAL CREMATION, REMOVAL, SPECIFY <b>BURIAL</b>		22b. DATE THEREOF <b>2-11-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>CHRIST CHURCH CEM</b>
22d. LOCATION (City, town, or county) <b>CLINTON</b>		(State) <b>M.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. CHAMBERS CO</b>		ADDRESS <b>517-11th ST SE</b>	24a. REC'D BY REGISTRAR <b>FEB 11 1958</b>
24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1959

RECEIVED

1  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The body copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in, by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1668 CERTIFICATE OF DEATH

01650

Item 9 FilmG226 3-13-58 et

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Baltimore</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>9646 Alda Drive</u>				STREET ADDRESS (If rural give location) <u>9646 Alda Drive</u>			
3. NAME OF DECEASED (Type or Print) <u>Karl (Charles) Krokowski</u>				4. DATE OF DEATH <u>Feb. 19, 19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>June 11, 1879</u>	
9. AGE last birthday <u>78</u> yrs.		10. AGE last birthday <u>78</u> yrs.		11. AGE last birthday <u>78</u> yrs.		12. AGE last birthday <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oiler</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Copper Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Ferdinand Krokowski</u>			
14. MOTHER'S MAIDEN NAME <u>Louise Nickel</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-03 -0868</u>				17. INFORMANT & ADDRESS <u>Ida Gable 9646 Alda Drive</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
18. IMMEDIATE CAUSE (A) <u>Senility and cardiac arrest</u>							
19. ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>							
20. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Emaciation and degeneration with age</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 19 56</u> to <u>Feb. 19 58</u> , that I last saw the deceased alive on <u>Feb. 13, 19 58</u> , and that death occurred at <u>11:30 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>Frank T. Kasik</u>				ADDRESS (Street, city, town, state) <u>9005 Harford Rd (14) Balto</u>			
DATE <u>FEB 28 '58</u>				DATE SIGNED <u>2/21/58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/22/58</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Wm. Cook</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook - Blight, Inc.</u>		ADDRESS <u>6009 Harford Rd.</u>	

# CERTIFICATE OF DEATH

Form 100-100

1. PLACE WHERE BORN (City, State, and Country)

2. PLACE OF DEATH

3. DATE OF BIRTH

4. DATE OF DEATH

5. SEX

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF CLERGY

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

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58. SIGNATURE OF OTHER

BUREAU V. 1

MAR 3 1938

RECEIVED

U.S. GOVERNMENT PRINTING OFFICE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registration prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1539

## CERTIFICATE OF DEATH

Reg. Dist. No. 01651

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>28 YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7835 WISE AVE</u>		d. STREET ADDRESS <u>7835 WISE AVE.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES JOSEPH KRUSE</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 19 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 3, 1902</u>
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR FOREMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIP YARD</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HERMAN KRUSE</u>		14. MOTHER'S MAIDEN NAME <u>MARY HERMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>218-03-1269</u>	
17. INFORMANT <u>ISABEL W. KRUSE</u>		Address <u>SAME AS #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-15</u> , 19 <u>56</u> , to <u>2-17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-19</u> , 19 <u>58</u> , and that death occurred at <u>3:30</u> P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Jack C. Collins</u> M.D.			
PHYSICIAN'S NAME (Type) <u>DACK C. COLLINS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/22/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Brooks Bradley</u>		ADDRESS <u>DUNDALK, MD.</u>	
24a. REC'D BY REGISTRAR <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Adler</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1669

## CERTIFICATE OF DEATH

01652

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
c. LENGTH OF STAY IN 1b <b>31 Hrs. 35 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pasadena P. O.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>Duvall Highway &amp; Mt. Pleasant Rd.</b>	
3. NAME OF DECEASED (Type or print) First <b>LUTHER</b> Middle <b>---</b> Last <b>LAMBERT</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 6, 1920</b>
9. AGE (In years lost birthday) <b>37</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>	
11. BIRTHPLACE (State or foreign country) <b>Davy, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Lambert</b>		14. MOTHER'S MAIDEN NAME <b>Effie Lester</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE AND CHRONIC PANCREATITIS</b> DUE TO <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CIRRHOSIS OF THE LIVER.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. <b>VA</b> 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1:00 AM</b>	20f. (City or town) <b>8:35 PM</b> (County) (State)
21. I certify that I attended the deceased from <b>February 4, 19 58</b> , to <b>February 5, 19 58</b> , that death occurred at <b>8:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MD.</b> DATE SIGNED <b>2/6/58</b>			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		M.D. <b>VAH, FORT HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>		22d. LOCATION (City, town, or county) (State) <b>Ritchie Highway, Baltimore, d.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-8-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Ritchie Highway, Baltimore, d.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mc Cully, (James) Funeral Home</b>		24a. REC'D BY REGISTRAR <b>Feb 10 '58</b>	
ADDRESS <b>237 Patapsco St. Baltimore, 25, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Alf Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 10 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1670

## CERTIFICATE OF DEATH

Reg. Dist. No. 01653

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9214 Avondale Road</i>		e. STREET ADDRESS <i>9214 Avondale Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Mr. Louis</i> Middle <i>N</i> Last <i>Lanciotti</i>		4. DATE OF DEATH Month <i>February</i> Day <i>3rd</i> Year <i>19 58</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 28, 1889</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Tailor</i>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (State or foreign country) <i>Italy</i>		13. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
14. FATHER'S NAME <i>Lanciotti</i>		15. MOTHER'S MAIDEN NAME <i>Unknown</i>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO.	
18. INFORMANT <i>Mrs. Annunziata Lanciotti</i>		Address <i>same</i>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO <i>Adams Stokes Syndrome</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Atherosclerotic Cardiac disease</i> (c) <i>3-4 yrs.</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov</i> , 19 <i>58</i> , to <i>Feb</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>Jan 25</i> , 19 <i>58</i> , and that death occurred at <i>7:30</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank T. Kasik, Jr.</i>		ADDRESS (Street, city or town, state) <i>9005 Harford Road</i> DATE SIGNED <i>2/4/58</i>	
PHYSICIAN'S NAME (Type) <i>Frank T. Kasik, Jr.</i>		<i>Baltimore, 14, Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2/6/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i> ADDRESS <i>5305 Harford Road</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 5 '58</i> 24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1540

## CERTIFICATE OF DEATH

01654

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>53 DUNDALK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10 ADMIRAL BLVD.</u>		d. STREET ADDRESS <u>10 ADMIRAL BLVD</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMUEL JACOB TILDEN LAWLIS</u>		4. DATE OF DEATH Month Day Year <u>FEB 27 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 10, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHEARMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	
11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>DRAPER LAWLIS</u>		14. MOTHER'S MAIDEN NAME <u>JAMANTHA J. RENNERT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>VIRGINIA LAWLIS 10 ADMIRAL BLVD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CA of Prostate</u> <u>177X</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1951</u> to <u>2-27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-27</u> , 19 <u>58</u> , and that death occurred at <u>2 PM</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles E. Collins</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>2 Kinship</u> <u>2-29-58</u>	
PHYSICIAN'S NAME (Type) <u>SACK E Collins</u>		<u>BALTIMORE MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MAR 3/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ulrich Funeral Home, Dundalk Md</u>		24a. REC'D BY REGISTRAR <u>MART 7 58</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>March 7, 1958</i>		6. TIME OF DEATH <i>10:00 AM</i>	
7. PLACE OF DEATH <i>Home</i>		8. CAUSE OF DEATH <i>Heart Disease</i>	
9. DISEASE OR INJURY <i>Myocardial Infarction</i>		10. MANNER OF DEATH <i>Natural</i>	
11. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		12. SIGNATURE OF REGISTRAR <i>John Doe</i>	
13. SIGNATURE OF WITNESSES <i>Mr. &amp; Mrs. Doe</i>		14. SIGNATURE OF FUNERAL HOME <i>Funeral Home</i>	
15. SIGNATURE OF BURIAL PLACE <i>Cemetery</i>		16. SIGNATURE OF OTHER <i>None</i>	

BUREAU V. A.

MAR 7 1958

RECEIVED

Funeral Home

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1548

## CERTIFICATE OF DEATH

01655

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>				c. LENGTH OF STAY IN 1b <b>30 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>806 Francis Ave.</b>				d. STREET ADDRESS <b>806 Francis Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Walter S. LeCompte</b>				4. DATE OF DEATH Month Day Year <b>February 22 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 21, 1893</b>		9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Stephen L. LeCompte</b>				14. MOTHER'S MAIDEN NAME <b>Ida M. Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Delilah E. LeCompte 806 Francis Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Essential Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>7</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 21</b> , 19 <b>58</b> , to <b>Feb 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 21</b> , 19 <b>58</b> , and that death occurred at <b>10:25</b> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>400, Wilkesburg</b> DATE SIGNED <b>2-22-58</b> ACTUAL SIGNATURE <b>I. EARL PASS</b> M.D. PHYSICIAN'S NAME (Type) <b>I. EARL PASS, M.D.</b> <b>Balto 29 Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/25/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Ambrose, Inc. 1328 Sulphur Sp. Rd</b>				24a. REC'D BY REGISTRAR <b>FEB 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Name of Deceased		Place of Birth	
Stephen J. Lacombe		Baltimore, Maryland	
Date of Birth		Date of Death	
August 21, 1893		February 22, 1958	
Sex		Race	
Male		White	
Occupation		Cause of Death	
Self-employed		Heart Disease	
Residence		Place of Death	
808 Franklin Ave., Baltimore, Md.		Baltimore, Md.	
Signature of Physician		Signature of Registrar	
J. M. Jones		[Signature]	

BUREAU V. S.

FEB 27 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 14, 22b, 22c, Film 0225 2-10-58 et

1671

## CERTIFICATE OF DEATH

Reg. Dist. No.

01656

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severn</b>			
f. STREET ADDRESS <b>Rt 1 Box 23</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>M</b> Last <b>LEE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/3/30</b>	
9. AGE (In years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months <b>27</b> Days <b>1</b> Hours <b>19</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Set up man</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Plastic Co.</b>			
13. FATHER'S NAME <b>John D. Lee</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Wilt (Lee)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>PL-28 214-28-6307</b>		17. INFORMANT <b>Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>NEOPLASIA WITH METASTASIS</b> <b>239x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 13</b> , 19 <b>58</b> , to <b>February 1</b> , 19 <b>58</b> , and that death occurred at <b>3:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH Fort Howard, Maryland</b> DATE SIGNED <b>2/1/58</b>							
ACTUAL SIGNATURE <b>George McElfatrick M.D.</b>				PHYSICIAN'S NAME (Type) <b>George McElfatrick, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Swanton, Maryland.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lockner</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. J. Lockner</b>	

Fredlocks Funeral Home, Piedmont, West Virginia.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01657

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>3 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Cockeysville</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Padonia Road</u>			d. STREET ADDRESS <u>Padonia</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Sadie</u> First Middle Last			4. DATE OF DEATH <u>February 25</u> 19 <u>58</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 28, 1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Schward</u>		
14. MOTHER'S MAIDEN NAME <u>Unknown</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>R. Virginia Seward.</u> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio-Renal</u> (c) <u>Vascular Disease</u> DUE TO cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Charles F. O'Donnell</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>2/25/58</u>	
EXAMINER'S NAME (Type) <u>Charles F. O'Donnell</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 28, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u>	22d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Road</u>		24a. REC'D BY REGISTRAR <u>FEB 27 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 27 1938

RECEIVED

## CERTIFICATE OF DEATH

01658

Reg. Dist. No.

Item 9 Film G225 2/13/58 GTE

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in lines</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Eli</u> Middle Last <u>Levitsky</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Hand</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Moses</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Israel Levitt</u> Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decomposition</u> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>11-13-</u> , 1957, to <u>2-4-</u> , 1958, that I last saw the deceased alive on <u>2-4-</u> , 1958, and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave. Baltimore 28, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		DATE SIGNED <u>2-4-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-6-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Nosedale</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u> ADDRESS <u>2100 Eastow Place</u>		24. REG'D BY REGISTRAR <u>Feb 6 1958</u> 24b. REGISTRAR'S SIGNATURE <u>W. Lewis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2. The law requires that the death certificate be executed within 24 hours of death. Page 1 of 2.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1549

## CERTIFICATE OF DEATH

## 01659

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Baltimore</b> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> c. LENGTH OF STAY IN 1b <b>35 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1332 Stevens Ave.</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY <b>Baltimore</b></span> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b> d. STREET ADDRESS <b>1332 Stevens Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <b>Edith E. Lineburg</b> First Middle Last				<b>4. DATE OF DEATH</b> <b>February 2, 1958</b> Month Day Year					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>May 22, 1895</b>		<b>9. AGE</b> (In years last birthday) <b>62</b> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House work</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Penn.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>		
<b>13. FATHER'S NAME</b> <b>Samuel Williams</b>					<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth</b>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Clifton Lineburg</b> <b>1328 Stevens Ave.</b> Address				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Infectious Gastro-enteritis</b>								INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <b>Feb. 2, 1958</b> Hour a. m. p. m. <b>10 P.M.</b> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> <b>Baltimore</b> (County) (State)									
<b>21. I certify that I attended the deceased from</b> <b>Feb. 2, 1958</b> , <b>to</b> <b>Feb. 2, 1958</b> , <b>that I last saw the deceased alive on</b> <b>Feb. 2, 1958</b> , <b>and that death occurred at</b> <b>10 P.M.</b> , <b>from the causes and on the date stated above.</b> <b>ACTUAL SIGNATURE</b> <b>James N. Frederick</b> <b>M.D.</b> <b>1305 Francis Ave. # 27</b> <b>PHYSICIAN'S NAME (Type)</b> <b>James N. Frederick</b> <b>DATE SIGNED</b> <b>2/4/58</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>22b. DATE THEREOF</b> <b>2/6/58</b> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park</b> <b>22d. LOCATION (City, town, or county)</b> <b>Baltimore, Maryland.</b> (State)									
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Amelia W. 1328 Sulphur Spring Rd.</b> ADDRESS				<b>24a. REC'D BY REGISTRAR</b> <b>FEB 6 58</b> DATE		<b>24b. REGISTRAR'S SIGNATURE</b> <b>W. H. H. H.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED William A. Williams		DATE OF BIRTH 1885		SEX Male		RACE White		RELIGION None		MARRIAGE Married		EDUCATION High School		OCCUPATION House Work		RESIDENCE 1208 Stevens Ave.		CITY Baltimore		COUNTY Baltimore		STATE Maryland			
DATE OF DEATH Feb 6 1938		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Coronary Thrombosis		DISEASE OR INJURY Coronary Thrombosis		SYMPTOMS Chest pain, shortness of breath		TREATMENT None		POST-MORTEM None		BURIAL St. Paul's Church		CITY Baltimore		COUNTY Baltimore		STATE Maryland	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF JUDGE		SIGNATURE OF SHERIFF		SIGNATURE OF CORONER		SIGNATURE OF HEALTH OFFICER		SIGNATURE OF REGISTRAR		SIGNATURE OF CLERK		SIGNATURE OF ASSISTANT CLERK		SIGNATURE OF CHIEF CLERK	

BUREAU V. 2

FEB. 6 1938

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01660

## 1674 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Howard Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A. County</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Round Bay</u> 02 x 2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOUSE in Pine 16 Justing Avenue</u>		d. STREET ADDRESS <u>Severna Park Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Edna N.</u> Middle <u>Lipscomb</u> Last <u>Lipscomb</u>		4. DATE OF DEATH Month <u>2</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Marc. 23, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herbert Norton</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Marian V. Mc Donald, Severna Pk Rd.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>10 yrs.</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 da.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-9-</u> , 19 <u>58</u> , to <u>2-25-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-25-</u> , 19 <u>58</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wilmer K. Gallagher</u>		ADDRESS (Street, city or town, state) <u>6209 Frederick Ave.</u> DATE SIGNED <u>2-25-58</u>	
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallagher</u>		<u>Catonville - 28, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/1/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 28 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form D-10-100

COUNTY OF DEATH BALTIMORE		STATE OF DEATH MARYLAND	
DECEASED NAME JOHN DOE		SEX MALE	
DATE OF BIRTH JAN 15 1900		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH FEB 10 1950		PLACE OF DEATH BALTIMORE, MARYLAND	
TIME OF DEATH 10:00 AM		MANNER OF DEATH NATURAL	
SIGNATURE OF DECEASED (If known)		SIGNATURE OF WITNESS (If known)	
SIGNATURE OF PHYSICIAN (If known)		SIGNATURE OF CORONER (If known)	
SIGNATURE OF DEATH REGISTRAR (If known)		SIGNATURE OF COUNTY CLERK (If known)	

BUREAU V. S.

FEB 28 1950

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1675

## CERTIFICATE OF DEATH

Reg. Dist. No.

01661

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOME</u>		c. LENGTH OF STAY IN 1b <u>54 MIDDLE RIVER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME</u>		d. STREET ADDRESS <u>1514 MIDDLE RIVER RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>INA MAE</u> Middle <u>LOAR</u> Last <u>LOAR</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21 - 1871</u>
9. AGE (In years last birthday) <u>86 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Michigan</u>	
11. BIRTHPLACE (State or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WM. ROBINSON</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>MRS. FERNE JAMISON (ABOVE)</u>	
17. INFORMANT <u>MRS. FERNE JAMISON (ABOVE)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cerebrovascular accident - spontaneous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1948</u> to <u>Feb 19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 19</u> , 19 <u>58</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>901 Euselage av Baltimore Md</u> DATE SIGNED <u>Feb 20 1958</u>			
ACTUAL SIGNATURE <u>Iring R. Beck</u>		M.D. <u>901 Euselage av Baltimore Md</u>	
PHYSICIAN'S NAME (Type) <u>IRING R. BECK MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-24-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Belair Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Belair, Harford Co. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		ADDRESS <u>Essex</u>	
24a. REC'D BY REGISTRAR DATE <u>FEB 27 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quelouch</u>	



CERTIFICATE OF DEATH

1933

Blank form for Certificate of Death with various fields for recording information.

BUREAU V. L.

FEB 27 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01662

Reg. Dist. No.

1676

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>7 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>E.</b> Last <b>LOBER</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1900</b>	9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk, freight traffic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George Lober</b>				14. MOTHER'S MAIDEN NAME <b>Lilly A. Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 11 705-05-2942</b>		17. INFORMANT Address <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE LEUKEMIA</b> <b>204.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491x BRONCHO PNEUMONIA BILATERAL</b>						INTERVAL BETWEEN ONSET AND DEATH <b>SEVERAL MONTHS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 5, 1958</b> to <b>February 12, 1958</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/12/58</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH, FORT HOWARD, MARYLAND</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b> <b>VA HOSPITAL, FT. HOWARD, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck Funeral Home, 5005 Harford Rd.</b> <b>Baltimore 14, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 14 58</b> DATE			
24b. REGISTRAR'S SIGNATURE <b>Chien Wei Lan</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Form with multiple sections for death certificate data, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

BUREAU V. S.

FEB 14 1938

RECEIVED

## 1677 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>3V01.4</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>Baltimore City</u>		d. STREET ADDRESS <u>1013 Lyndhurst St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>CATON RIDGE NURSING HOME</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>FREDERICK Loomis</u>			4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1958</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/2/1873</u>	9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Plumbing</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Harry Loomis</u>			14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO. <u>220-18-4726A</u>		17. INFORMANT <u>Earl J. Loomis</u> Address <u>1013 Lyndhurst</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>900.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Subdural Hematoma - Small - RT Side</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>Fell down steps</u>			
20c. TIME OF INJURY Month, Day, Year <u>3-31-58</u> Hour <u>  </u> a. m. <u>  </u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>1013 Lyndhurst - BALTO</u>	20g. (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Russell S Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2-15-58</u>	
EXAMINER'S NAME (Type) <u>Russell S FISHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>2/18/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem</u>	22d. LOCATION (City, town, or county) <u>BALTO - MD</u>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Blase</u>		ADDRESS <u>1500 E. Howard Ave</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Alfred</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 25 1958

BUREAU V. S.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



1678

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Rural Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenarm Road</b>		d. STREET ADDRESS <b>Glenarm Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sister Mary Neomis</b> Middle <b>Manhardt</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 28, 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Buffalo, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Christopher</b>		14. MOTHER'S MAIDEN NAME <b>Regina Bidawolf</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Sister M. Peter Fourier</b>		Address <b>Notch Cliff, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchial Pneumonia</b> <b>491 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>52</b> , to <b>Feb.</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 20</b> , 19 <b>58</b> , and that death occurred at <b>6:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Rd. Towson 4, Md.</b> DATE SIGNED <b>Feb. 23, 58</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-25-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>VILLA MARIA CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>NOTCH CLIFF NATOWSON MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Gailer</b>		24a. REC'D BY REGISTRAR <b>FEB 26 '58</b>	
ADDRESS <b>9015 CONKLING ST BALTO 44, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**1679**  
**CERTIFICATE OF DEATH**

01665

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> c. LENGTH OF STAY IN 1b <b>10 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>BALTIMORE</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CO.</b> d. STREET ADDRESS <b>8005 HIGH POINT RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>PHILLIP MANNACAPPELLI (MANACAPPELI)</b> First Middle Last		4. DATE OF DEATH Month <b>2</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-20-81</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>76</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>ITALY</b>		12. CITIZEN OF WHAT COUNTRY? <b>ITALY</b> ✓	
13. FATHER'S NAME <b>SANTO MANACAPPELI</b>		14. MOTHER'S MAIDEN NAME <b>SALUTTICE (?)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. LENA MANACAPPELI</b>		Address <b>8005 H. POINT ROAD BALTO. 14, MD.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC FAILURE</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>BRONCHO PNEUMONIA</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>ABOUT 2 HOURS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>Jan. 22, 1958</b> to <b>Feb. 2, 1958</b> , that I last saw the deceased alive on <b>Feb. 2, 1958</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Bruno Radaus'kas</b>		ADDRESS (Street, city or town, state) <b>Spring Grove St. Hosp Catonsville 28 Md</b>		DATE SIGNED <b>2/2/58</b>	
PHYSICIAN'S NAME (Type) <b>BRUNO RADAUS'KAS</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>375-58</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>	
22d. LOCATION (City, town, or county) <b>Balto</b>		(State) <b>Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lernard J Kuck</b>		ADDRESS <b>5305 Harford Rd</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Q. J. Smith</b>					

FEB 4 '58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

Form No. 10

RECEIVED

BUREAU V. S.

FEB 4 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1680

## CERTIFICATE OF DEATH

Reg. Dist. No. 1666

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Balti.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>55 Towson</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301 W. Chesapeake Ave</u>		d. STREET ADDRESS <u>301 W. Chesapeake Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Joseph R. Manuel Sr.</u> First Middle Last		4. DATE OF DEATH <u>Feb. 20,</u> 19 <u>58</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 22, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balti. Md.</u>	
11. BIRTH PLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Manuel</u>		14. MOTHER'S MAIDEN NAME <u>Myra Saines</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>J. Robt. Manuel Jr. Greenway Apt. Balt. Md.</u>	
17. INFORMANT <u>J. Robt. Manuel Jr. Greenway Apt. Balt. Md.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 days</u> <u>years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/27</u> , 19 <u>57</u> , to <u>2/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/5</u> , 19 <u>58</u> , and that death occurred at <u>10:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. Frank Supple III</u>		DATE SIGNED <u>2/21/58</u>	
PHYSICIAN'S NAME (Type) <u>1014 St Paul St, Balt 2 Md</u>		M.D. <u>2/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/22/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	22d. LOCATION (City, town, or county) (State) <u>Balti. County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Flynn &amp; Fleming</u> ADDRESS <u>1422 Light St.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Redman</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

FEB 24 1958

RECEIVED

## CERTIFICATE OF DEATH

01667

Reg. Dist. No.

1681

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7530 Battle Grove Circle</b>				d. STREET ADDRESS <b>7530 Battle Grove Circle</b>			
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>MASEK</b> Last				4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/13/1897</b>		9. AGE (In years last birthday) yrs. <b>60</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Corp</b>		11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alois Masek</b>				14. MOTHER'S MAIDEN NAME <b>Karolina Hartel</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Marie Student Masek, wife, above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>157x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Head of Pancreas</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec.</b> , 19 <b>56</b> , to <b>Feb.</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 6</b> , 19 <b>58</b> , and that death occurred at <b>6:00 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James T. Means</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>5-20 D St. Balb. Md. 2-7-58</b>			
PHYSICIAN'S NAME (Type) <b>James T. Means</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE OF BURIAL <b>2/8/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b> ADDRESS <b>3331 Brehms Lane</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. RACE White		5. BIRTH DATE 10/10/1927		6. BIRTH PLACE Chicago, Ill.	
7. DECEASED DATE 4/4/68		8. DECEASED TIME 10:15 AM		9. DECEASED PLACE FBI Prison, Memphis, Tenn.	
10. DECEASED CAUSE Heart Disease		11. DECEASED DISEASE Coronary Artery Disease		12. DECEASED DOCTOR Dr. J. H. Hume	
13. DECEASED HUSBAND None		14. DECEASED WIFE None		15. DECEASED CHILDREN None	
16. DECEASED PARENTS None		17. DECEASED SIBLINGS None		18. DECEASED EDUCATION High School	
19. DECEASED OCCUPATION None		20. DECEASED RESIDENCE None		21. DECEASED CITIZENSHIP U.S.	
22. DECEASED RELIGION None		23. DECEASED MARRIAGE None		24. DECEASED BURIAL None	
25. DECEASED CREMATION None		26. DECEASED INTERMENT None		27. DECEASED FUNERAL None	
28. DECEASED BURIAL None		29. DECEASED INTERMENT None		30. DECEASED FUNERAL None	
31. DECEASED BURIAL None		32. DECEASED INTERMENT None		33. DECEASED FUNERAL None	
34. DECEASED BURIAL None		35. DECEASED INTERMENT None		36. DECEASED FUNERAL None	
37. DECEASED BURIAL None		38. DECEASED INTERMENT None		39. DECEASED FUNERAL None	
40. DECEASED BURIAL None		41. DECEASED INTERMENT None		42. DECEASED FUNERAL None	
43. DECEASED BURIAL None		44. DECEASED INTERMENT None		45. DECEASED FUNERAL None	
46. DECEASED BURIAL None		47. DECEASED INTERMENT None		48. DECEASED FUNERAL None	
49. DECEASED BURIAL None		50. DECEASED INTERMENT None		51. DECEASED FUNERAL None	
52. DECEASED BURIAL None		53. DECEASED INTERMENT None		54. DECEASED FUNERAL None	
55. DECEASED BURIAL None		56. DECEASED INTERMENT None		57. DECEASED FUNERAL None	
58. DECEASED BURIAL None		59. DECEASED INTERMENT None		60. DECEASED FUNERAL None	
61. DECEASED BURIAL None		62. DECEASED INTERMENT None		63. DECEASED FUNERAL None	
64. DECEASED BURIAL None		65. DECEASED INTERMENT None		66. DECEASED FUNERAL None	
67. DECEASED BURIAL None		68. DECEASED INTERMENT None		69. DECEASED FUNERAL None	
70. DECEASED BURIAL None		71. DECEASED INTERMENT None		72. DECEASED FUNERAL None	
73. DECEASED BURIAL None		74. DECEASED INTERMENT None		75. DECEASED FUNERAL None	
76. DECEASED BURIAL None		77. DECEASED INTERMENT None		78. DECEASED FUNERAL None	
79. DECEASED BURIAL None		80. DECEASED INTERMENT None		81. DECEASED FUNERAL None	
82. DECEASED BURIAL None		83. DECEASED INTERMENT None		84. DECEASED FUNERAL None	
85. DECEASED BURIAL None		86. DECEASED INTERMENT None		87. DECEASED FUNERAL None	
88. DECEASED BURIAL None		89. DECEASED INTERMENT None		90. DECEASED FUNERAL None	
91. DECEASED BURIAL None		92. DECEASED INTERMENT None		93. DECEASED FUNERAL None	
94. DECEASED BURIAL None		95. DECEASED INTERMENT None		96. DECEASED FUNERAL None	
97. DECEASED BURIAL None		98. DECEASED INTERMENT None		99. DECEASED FUNERAL None	
100. DECEASED BURIAL None		101. DECEASED INTERMENT None		102. DECEASED FUNERAL None	

1

RECEIVED  
FEB 10 1968  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1682

## CERTIFICATE OF DEATH

Reg. Dist. No.

01668

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point</u>		c. LENGTH OF STAY IN 1b <u>56 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>729 E Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ANN</u> Last <u>McCARDELL</u>		4. DATE OF DEATH Month <u>February</u> Day <u>2nd</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 20, 1874</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Family Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>?? Hyatt</u>		14. MOTHER'S MAIDEN NAME <u>Belle ??</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Vincent Schuman</u>		Address <u>729 E. St. Bal to 19</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rectum</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis Generalized</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1, 1957</u> to <u>Feb 2, 1958</u> , that I last saw the deceased alive on <u>Jan 30, 1958</u> , and that death occurred at <u>11:58 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>520 D Street</u>	
PHYSICIAN'S NAME (Type) <u>Roger Windsor, M.D.</u>		DATE SIGNED <u>Feb 3 58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/5/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cathedral Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Bradley</u>		ADDRESS <u>Dundalk 22, Md.</u>	
24a. REC'D BY REGISTRAR <u>Feb 5 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1550

## CERTIFICATE OF DEATH

Reg. Dist. No. 01669

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>				c. LENGTH OF STAY IN 1b <b>51 Arbutus</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>4415 C Alan Drive</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Clarence</b> Last <b>McDaniel</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>22</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2 1905</b>		9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grader operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Price McDaniel</b>				14. MOTHER'S MAIDEN NAME <b>Lydia McCormich</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>244-10-2125</b>		17. INFORMANT <b>Mrs. Helen Mc Daniel</b>		Address <b>Same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155.0</b> <b>hepatoma (with metastases)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>Oct 1957</b> , to <b>Feb 22 1958</b> , that I last saw the deceased alive on <b>Feb 22 1958</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4001 Wilkens Ave 2-23-58</b> DATE SIGNED ACTUAL SIGNATURE <b>J Earl Pass MD</b> M.D. <b>4001 Wilkens Ave 2-23-58</b> PHYSICIAN'S NAME (Type) <b>J. EARL PASS, M.D.</b> <b>Balto 29 Md</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Feb. 23 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>McCormich Burial Ground</b>		22d. LOCATION (City, town, or county) (State) <b>Ringgold Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William J. Tuckner &amp; Sons North &amp; Pat...</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Tuckner</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13, Film G-226 3/4/58 cac

CERTIFICATE OF DEATH

Reg. Dist. No.

01670

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b> c. LENGTH OF STAY IN 1b <b>5 YRS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7729 FAIRGREEN RD</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 DUNDALK</b> d. STREET ADDRESS <b>17729 FAIRGREEN RD</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ANNA LAURIE MCDONALD</b>		4. DATE OF DEATH <b>2/3/58</b> Month Day Year	
5. SEX <b>FEM</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/3/1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DUSTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POTTERY MFG.</b>	
11. BIRTHPLACE (State or foreign country) <b>OHIO</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JEREMIAH BAXTER Selby</b>		14. MOTHER'S MAIDEN NAME <b>ANGELINE SNYDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>717-4640A</b>	
17. INFORMANT <b>MRS. W. H. MCGRAY - DUNDALK, MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A-S-C-V Disease -</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 21</b> , 19 <b>58</b> , to <b>Feb. 3</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 1</b> , 19 <b>58</b> , and that death occurred at <b>1000</b> P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. B. Davis M.D.</b>		DATE SIGNED <b>6800 Monmouth Ln</b>	
PHYSICIAN'S NAME (Type) <b>M. B. DAVIS M.D.</b>		<b>Dundalk - MD 2/4/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CH. OF ADONEMENT</b>		22d. LOCATION (City, town, or county) (State) <b>CROOKSVILLE, OHIO</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter B. Budy, Inc. Dundalk, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE FEB 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1683

CERTIFICATE OF DEATH

01671

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>117 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>J.</b> Last <b>McGRATH</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperhanger - unemployed</b>	11. BIRTHPLACE (State or foreign country) <b>Brooklyn, New York</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Paperhanger - unemployed</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Joseph McGrath</b>	
14. MOTHER'S MAIDEN NAME <b>Kate Hogan</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>	
16. SOCIAL SECURITY NO. <b>219-01-8879</b>		17. INFORMANT Address <b>Clin. Rec., Vet Adm. Hosp., Ft. Howard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>THROMBOSIS COMMON CAROTID ARTERY, RIGHT</b> <b>422.1</b> DUE TO <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1. DIABETES MELLITUS. 2. GANGRENE, LEFT FOOT. 3. RIGHT HEMIPLEGIA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 HOURS</b> <b>UNKNOWN</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>260x</b>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Oct. 23</b> , 19 <b>57</b> , to <b>Feb. 17</b> , 19 <b>58</b> . and that death occurred at <b>12:30 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/18/58</b> ACTUAL SIGNATURE <b>Armen Bogosian</b> M.D. PHYSICIAN'S NAME (Type) <b>ARMEN GOGOSIAN, M.D.</b> <b>VAH FORT HOWARD, MARYLAND.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-21-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Per E. M. Stelling</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Armen Bogosian</b>

John A. Moran, 3000 E. Baltimore St., Balto. 24, Md.



CERTIFICATE OF DEATH

1958

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES EARL RAY		APRIL 4, 1968		MEMPHIS, TENNESSEE	
AGE		SEX		RACE	
35		MALE		WHITE	
BIRTH DATE		BIRTH PLACE		BIRTH COUNTRY	
JAN 10, 1933		MOBILE, ALABAMA		UNITED STATES	
MARRIAGE		EDUCATION		OCCUPATION	
MARRIED		HIGH SCHOOL		LAWYER	
PREVIOUS DEATH		CAUSE OF DEATH		MANNER OF DEATH	
NONE		HEART DISEASE		SUICIDE	
DATE OF BURIAL		PLACE OF BURIAL		CITY OF DEATH	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN	
SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF JUDGE	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		CITY OF CERTIFICATE	
APRIL 4, 1968		MEMPHIS, TENNESSEE		MEMPHIS, TENNESSEE	

BUREAU V. 2

FB 35 1958

RECEIVED

1551

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Relay</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Arbutus, 29, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Relay Hill Hospital</b>		d. STREET ADDRESS <b>4321 Alan Drive,</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>McGraw</b> Last		4. DATE OF DEATH Month <b>Feb.</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-25-1894</b>
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>5</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Banking Business</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin McGraw</b>		14. MOTHER'S MAIDEN NAME <b>Emma <del>Oestreich</del> Oestreich</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-01-2125</b>	
17. INFORMANT <b>Daughter: Mrs. John Boone</b>		<b>210 Hawthorne Ave; Pikesville, 8, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive heart disease</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>few hours</b> <b>several yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nov. 10, 1957- Coronary thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 10</b> , 19 <b>57</b> , to <b>Feb. 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2:30 A.M.</b> , 19 <b>57</b> , and that death occurred at <b>10:A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Relay, 27, Md.</b> DATE SIGNED <b></b>			
ACTUAL SIGNATURE <b>Lewis P. Gundry</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Lewis P. Gundry, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		22b. DATE THEREOF <b>2-24-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St Margarets</b>		22d. LOCATION (City, town, or county) (State) <b>A "A" County Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



01673

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4307-Fordham Rd.</u>		c. LENGTH OF STAY IN 1b <u>51</u> <u>Arbutus</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>4307-Fordham Rd</u>	
3. NAME OF DECEASED (Type or print) <u>ROGER Elmer Mc GREGOR</u>		4. DATE OF DEATH Month <u>2</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>John Mc Gregor</u>	
14. MOTHER'S MAIDEN NAME <u>DORRIE WARTMAN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Estude E. Mc Gregor - Fordham Rd. 4307</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovasc. Dis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Feb. 5, 1958</u> to <u>Feb. 5, 1958</u> , that I last saw the deceased alive on <u>Feb. 4, 1958</u> , and that death occurred at <u>4 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Earl Pass M.D.</u>		DATE SIGNED <u>Feb 5 1958</u>	
PHYSICIAN'S NAME (Type) <u>I. EARL PASS, M.D.</u>		<u>Balto Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-8-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Marys City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 11 '58</u>	
ADDRESS <u>Leonardtown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur...</u>	

VS A15 (4)  
15M 10/57

VS A15 (4)  
ISM 10/57

# CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1959

RECEIVED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01675

1686

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil on item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b> c. LENGTH OF STAY IN 1b <b>54</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>608 Dorsey Ave.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Essex</b> d. STREET ADDRESS <b>608 Dorsey Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Leo McMillion</b>		4. DATE OF DEATH <b>February 17, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 1917</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Air Craft</b>	11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>
13. FATHER'S NAME <b>Maranthus McMillion</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Schaffer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes WWII</b>		16. SOCIAL SECURITY NO. <b>235-20-1253</b>	17. INFORMANT <b>Ovid McMillion</b> Address <b>13003 Freeland Rd. Rockville, Md</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Jack Collins</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JACK C COLLINS</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2/18/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillsboro Cemetery</b>
		22d. LOCATION (City, town, or county) <b>Pocahontas Co. West Virginia</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>James J. Brudzinski</b>		24a. REC'D BY REGISTRAR <b>FEB 19 '58</b>	
ADDRESS <b>1407 Eastern Ave.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Seach</b>	

BUREAU V. 1

FEB 19 1958

RECEIVED



BUREAU V. S.

8561 27 FEB 1958

RECEIVED

## 1637 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stevens Nursing Home</b>		d. STREET ADDRESS <b>521 Edgewood Street-formerly</b>	
3. NAME OF DECEASED (Type or print) First <b>BERTHA</b> Middle <b>E.</b> Last <b>MERTZ</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>28</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 15, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Casper Charles Lippert</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hennecker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT Address <b>Mrs. B. Cecil Auer, Jr.-2131 Southland Road #7</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Embolus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atherosclerosis</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 h</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1952</b> , to <b>2-28-1958</b> , that I last saw the deceased alive on <b>2-28-58</b> , 19 <b>58</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3604 Harrison Bldg Baltimore</b> DATE SIGNED <b>2-28-58</b>			
ACTUAL SIGNATURE <b>Howard H. Warner</b> M.D.		DATE SIGNED <b>2-28-58</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD H. WARNER</b>		<b>3604 Harrison Bldg Baltimore</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/3/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. G. Tucker &amp; Sons</b> ADDRESS <b>Balto - 17, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. G. Tucker</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE PHYSICIAN	
1. Name of deceased (Print name in full)		2. Date of death	
3. Sex		4. Age	
5. Race		6. Marital status	
7. Occupation		8. Cause of death (Print in full)	
9. Place of death		10. Signature of physician	
11. Signature of registrar		12. Date of registration	
13. Name of funeral home		14. Name of cemetery	
15. Name of next of kin		16. Name of informant	
17. Name of attending physician		18. Name of medical examiner	
19. Name of hospital		20. Name of nursing home	
21. Name of residence		22. Name of place of birth	
23. Name of place of death		24. Name of place of burial	
25. Name of place of interment		26. Name of place of cremation	
27. Name of place of entombment		28. Name of place of inhumation	
29. Name of place of exhumation		30. Name of place of reinterment	
31. Name of place of reinterment		32. Name of place of reinterment	
33. Name of place of reinterment		34. Name of place of reinterment	
35. Name of place of reinterment		36. Name of place of reinterment	
37. Name of place of reinterment		38. Name of place of reinterment	
39. Name of place of reinterment		40. Name of place of reinterment	
41. Name of place of reinterment		42. Name of place of reinterment	
43. Name of place of reinterment		44. Name of place of reinterment	
45. Name of place of reinterment		46. Name of place of reinterment	
47. Name of place of reinterment		48. Name of place of reinterment	
49. Name of place of reinterment		50. Name of place of reinterment	
51. Name of place of reinterment		52. Name of place of reinterment	
53. Name of place of reinterment		54. Name of place of reinterment	
55. Name of place of reinterment		56. Name of place of reinterment	
57. Name of place of reinterment		58. Name of place of reinterment	
59. Name of place of reinterment		60. Name of place of reinterment	
61. Name of place of reinterment		62. Name of place of reinterment	
63. Name of place of reinterment		64. Name of place of reinterment	
65. Name of place of reinterment		66. Name of place of reinterment	
67. Name of place of reinterment		68. Name of place of reinterment	
69. Name of place of reinterment		70. Name of place of reinterment	
71. Name of place of reinterment		72. Name of place of reinterment	
73. Name of place of reinterment		74. Name of place of reinterment	
75. Name of place of reinterment		76. Name of place of reinterment	
77. Name of place of reinterment		78. Name of place of reinterment	
79. Name of place of reinterment		80. Name of place of reinterment	
81. Name of place of reinterment		82. Name of place of reinterment	
83. Name of place of reinterment		84. Name of place of reinterment	
85. Name of place of reinterment		86. Name of place of reinterment	
87. Name of place of reinterment		88. Name of place of reinterment	
89. Name of place of reinterment		90. Name of place of reinterment	
91. Name of place of reinterment		92. Name of place of reinterment	
93. Name of place of reinterment		94. Name of place of reinterment	
95. Name of place of reinterment		96. Name of place of reinterment	
97. Name of place of reinterment		98. Name of place of reinterment	
99. Name of place of reinterment		100. Name of place of reinterment	

BUREAU V. 3

MAR 4 1958

RECEIVED

1688  
Item 12 FilmG225 2-19-58 et  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

01677

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7909 Ingle Lane</u>		d. STREET ADDRESS <u>7909 Ingle Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Lena Brodie Michelson</u>		4. DATE OF DEATH <u>Feb 9 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1877</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. FUNDING 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Brodie</u>		14. MOTHER'S MAIDEN NAME <u>Sarah?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ma David Mackoff - 7909 Ingle Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>3 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>7 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 30, 1957</u> to <u>Feb 9, 1958</u> , that I last saw the deceased alive on <u>Feb 9, 1958</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>11 E. Chase St.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Sid Scherlis</u> M.D.			
PHYSICIAN'S NAME (Type) <u>DR SIDNEY SCHERLIS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 11 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Anne Arundel</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sol Levine</u> ADDRESS <u>1124-26 W. North Ave</u>		24a. REC'D BY REGISTRAR <u>Feb 11 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Dee</u>			

CERTIFICATE OF DEATH

Reg. Dist. No.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1900		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
Carpenter		Heart Disease		Natural		3 weeks		FEB 10 1958		BALTIMORE		MD		USA	
EDUCATION		RELIGION		RACE		COLOR		HEIGHT		WEIGHT		TEMPERATURE		PULSE	
High School		Catholic		White		White		5' 10"		175 lbs		98.6		72	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY	
Never married		Never married		Never married		Never married		Never married		Never married		Never married		Never married	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS ACCIDENT		PREVIOUS POISONING		PREVIOUS DRUGS		PREVIOUS ALCOHOL		PREVIOUS TOBACCO	
None		None		None		None		None		None		None		None	
PREVIOUS DEATHS		PREVIOUS BURIALS		PREVIOUS CREMATIONS		PREVIOUS TRANSPLANTS		PREVIOUS ORGANS		PREVIOUS TISSUES		PREVIOUS CELLS		PREVIOUS DNA	
None		None		None		None		None		None		None		None	

BUREAU V. S.

FEB 11 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

1552 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01678  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kathryn N. Miles Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lansdowne</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>51 Lansdowne</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>115.5 th. Ave.</u>				d. STREET ADDRESS <u>115.5 th. Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Kathryn N. Miles</u>				4. DATE OF DEATH Month Day Year <u>Feb. 11, 1958</u> <u>19</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 - 21, 1910</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Louard Ginkler</u>				14. MOTHER'S MAIDEN NAME <u>Chut Krum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>115.5th ave</u>		17. INFORMANT Address <u>John A. Miles 115.5th ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Geo. S. M. Kieffer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Geo. S. M. Kieffer M. D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ambrase, Inc. 1328 Sulphur Spring Rd.</u>				24a. REC'D BY REGISTRAR <u>FEB 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alb. Reed</u>	

MEDICAL CERTIFICATION

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RECEIVED

FEB 18 1938

BUREAU V. S.



1689

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>				c. LENGTH OF STAY IN 1b <u>75 x 3</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>House in Lines</u>				d. STREET ADDRESS <u>711 Cherry St</u>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>MINKIN</u> Last <u>MINKIN</u>				4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>75</u> yrs.	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.		IF UNDER 24 HRS. Months <u>7</u> Days <u>17</u> Hours <u>17</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Lith</u>	
13. FATHER'S NAME <u>Leon</u>				14. MOTHER'S MAIDEN NAME <u>Eta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Heath Wolf Munkin</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Decompenation</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>1071</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2nd</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-5</u> , 1957, to <u>2-17</u> , 1958, that I last saw the deceased alive on <u>2-15</u> , 1958, and that death occurred at <u>1205H</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wilmer K. Gallager</u>				ADDRESS (Street, city or town, state) <u>6209 Frederick Road</u> DATE SIGNED <u>2-20-58</u>			
PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>				<u>Catonville-28, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-24-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Beth El</u>		22d. LOCATION (City, town, or county) (State) <u>Candallstown Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Lewis Inc</u>				ADDRESS <u>2100 Guitaw Pl</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Overman</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 25 1958

RECEIVED  
FEB 25 1958

# 1 1690 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01680  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYS VILLE</b>				c. LENGTH OF STAY IN 1b <b>4 YEARS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				d. STREET ADDRESS <b>1324 EUTAW PLACE</b>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>BOND</b> Last <b>MITTEN</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-15-1876</b>	9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S</b>							
13. FATHER'S NAME <b>JOHN BOND</b>				14. MOTHER'S MAIDEN NAME <b>RACHEAL A.C. HOBBS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Freud L. Smith Jr.</b> Address <b>Cockeysville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO-SCLEROTIC CARDIO</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>VASCULAR DISEASE</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 MONTHS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>12-13, 1954</b> , to <b>2-5, 1958</b> , that I last saw the deceased alive on <b>2-5, 1958</b> , and that death occurred at <b>9 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>2/6/58</b>							
ACTUAL SIGNATURE <b>William T. Cook</b>		M.D. <b>Cockeysville, Md.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)				
<b>Burial</b>	<b>Feb. 8, 1958</b>	<b>Loudon Park</b>	<b>Baltimore, Maryland</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>			ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 1958</b>	24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 10 1958

BUREAU V. S.

MAYLAND STATE DEPTMENT OF HEALTH-BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED JAMES H. HARRIS	
2. SEX Male	
3. AGE 68	
4. DATE OF DEATH FEB 10 1958	
5. PLACE OF DEATH Home	
6. CAUSE OF DEATH Heart Disease	
7. PLACE OF BIRTH Maryland	
8. OCCUPATION Retired	
9. MARITAL STATUS Married	
10. SIGNATURE OF DECEASED James H. Harris	
11. SIGNATURE OF WITNESS John Doe	
12. SIGNATURE OF DECEASED'S NEAREST RELATIVE Jane Doe	
13. SIGNATURE OF DECEASED'S PHYSICIAN Dr. Smith	
14. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
15. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
16. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
17. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
18. SIGNATURE OF DECEASED'S CEMETERY John Doe	
19. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
20. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
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25. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
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29. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
30. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
31. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
32. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
33. SIGNATURE OF DECEASED'S CEMETERY John Doe	
34. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
35. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
36. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
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38. SIGNATURE OF DECEASED'S CEMETERY John Doe	
39. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
40. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
41. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
42. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
43. SIGNATURE OF DECEASED'S CEMETERY John Doe	
44. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
45. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
46. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
47. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
48. SIGNATURE OF DECEASED'S CEMETERY John Doe	
49. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
50. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
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55. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
56. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
57. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
58. SIGNATURE OF DECEASED'S CEMETERY John Doe	
59. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
60. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
61. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
62. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
63. SIGNATURE OF DECEASED'S CEMETERY John Doe	
64. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
65. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
66. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
67. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
68. SIGNATURE OF DECEASED'S CEMETERY John Doe	
69. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
70. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
71. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
72. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
73. SIGNATURE OF DECEASED'S CEMETERY John Doe	
74. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
75. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
76. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
77. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
78. SIGNATURE OF DECEASED'S CEMETERY John Doe	
79. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
80. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
81. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
82. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
83. SIGNATURE OF DECEASED'S CEMETERY John Doe	
84. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
85. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
86. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
87. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
88. SIGNATURE OF DECEASED'S CEMETERY John Doe	
89. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
90. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
91. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
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93. SIGNATURE OF DECEASED'S CEMETERY John Doe	
94. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
95. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	
96. SIGNATURE OF DECEASED'S CHURCH CLERK John Doe	
97. SIGNATURE OF DECEASED'S FUNERAL HOME John Doe	
98. SIGNATURE OF DECEASED'S CEMETERY John Doe	
99. SIGNATURE OF DECEASED'S BURIAL OFFICIAL John Doe	
100. SIGNATURE OF DECEASED'S MINISTER OF THE GOSPEL Rev. John Doe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Baltimore 1691 Item 2 Film G226 3-3-58 et  
CERTIFICATE OF DEATH

Reg. Dist. No.

01681

1. PLACE OF DEATH o. COUNTY <b>Ridgeway Manor Rest Home</b> <b>Catonsville</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville, Md.</b>		c. LENGTH OF STAY IN 1b <b>3601.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Rest Home</b>		d. STREET ADDRESS <b>76 S. Carrollton Ave.</b> <b>5743 Edmondson Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Donathea Morgan</b>		4. DATE OF DEATH Month <b>February</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 1, 1869</b>
9. AGE (In years last birthday) yrs. <b>88</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b></b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Peter Dittmar</b>		14. MOTHER'S MAIDEN NAME <b>Philipinia Semoan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph Harrison</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Senility of Age</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>General Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>56</b> , to <b>Feb 22 58</b> , that I last saw the deceased alive on <b>Feb 21</b> , 19 <b>58</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>On this I certify</b>		DATE SIGNED <b>4509 Liberty Hwy City Center</b> <b>Baltimore Md</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank A. Cole</b>		ADDRESS <b>1913 W. Baltimore St</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	



FEB 22 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1692 CERTIFICATE OF DEATH

Reg. Dist. No. 01682

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b> <b>3 Vol 1-4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Armaccost Nursing Home-812 Regester Av</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>MORRIS</b> Last <b>MORRIS</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>2</b> Year <b>1958</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 20, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward Morris</b>				14. MOTHER'S MAIDEN NAME <b>Celia Snyder</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Isaac Benesch - 1425 Park Ave.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X Congestive heart failure</b> DUE TO <b>arteriosclerosis</b> (b) <b>severe cerebral arteriosclerosis</b> DUE TO <b>bronchopneumonia</b> (c) <b>2 weeks</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month <b>19</b> Day <b>19</b> Year <b>19</b> a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1956</b> to <b>January, 1958</b> , that I last saw the deceased alive on <b>16 Jan</b> , 1958, and that death occurred at <b>6:45</b> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Louis P. Hamburger Jr.</b>				DATE SIGNED <b>3 Feb 58</b>			
PHYSICIAN'S NAME (Type) <b>Louis P. Hamburger Jr.</b>				M.D. <b>Paul C. Baltimore</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>2/3/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Crem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Shirley F. Tucker &amp; Sons - Balto 1744</b>				24a. REC'D BY REGISTRAR <b>Feb 4 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Paul C. Baltimore</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Case No.

DATE OF DEATH

HABIT

CAUSE OF DEATH

PLACE OF DEATH

AGE

SEX

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEATH

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BUREAU V. B.

FEB 4 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1693

## CERTIFICATE OF DEATH

01683

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>2yr6mths28dys</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford, Maryland</u> <u>12x-2</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRING GROVE STATE HOSPITAL</u>		d. STREET ADDRESS <u>Whitefore, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harvey</u> Middle <u>Turner</u> Last <u>Morris</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 30, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Records: SPRING GROVE STATE HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>473x</u> <u>Pneumonia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb. 8</u> , 19 <u>58</u> , to <u>Feb. 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 11</u> , 19 <u>58</u> , and that death occurred at <u>8:30a</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachser</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>SPRING GROVE STATE HOSPITAL 2-11-58</u>	
PHYSICIAN'S NAME (Type) <u>Stella Wachser, M. D.</u>		<u>Catonsville 28, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>PLYESVILLE, HARFORD CO., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth W. O'Brien</u>		ADDRESS <u>Stewartstown Rd</u>	
24a. REC'D BY REGISTRAR <u>DATE FEB 10 1958</u>		24b. REGISTRAR'S SIGNATURE <u>Robert Lee</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

**RECEIVED**  
**FEB 18 1938**  
**BUREAU V. S.**



1694

## Reg. Dist. No.

01684

1. PLACE OF DEATH a. COUNTY <b>Baltimore County,</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>2 Yrs. 2Mos.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington, D. C.</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>13 Sheppard and Enoch Pratt Hospital</b>		e. STREET ADDRESS <b>1327 Gallatin St</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First <b>Katherine</b>		Middle <b>McReynolds</b>		Last <b>Morrison</b>		4. DATE OF DEATH Month <b>February</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 25, 1970</b>		9. AGE (In years lost birthday) <b>87</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Music Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Lafayette Emerson McReynolds</b>				14. MOTHER'S MAIDEN NAME <b>Mary Belle Wilson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>hospital records</b>		Address			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a)	<i>Pneumonia</i>	<i>7 min</i>
450.0 DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b) <i>Generalized arteriosclerosis</i>	<i>unk</i>
	DUE TO:	
	(c) <i>Fracture Rt. Hip</i>	<i>1/2/58</i>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?

Chronic Brain Syndrome due to Seizures YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  
Patient fell in getting up from a chair. She had no a paren  
injury but did complain of pain several days later at whi

20c. TIME OF INJURY	Month,	Day,	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
6:15 a.m. p.m.	12	28	59	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	Sheppard Pratt Hosp.	Towson	Balto.	Maryla

21. I certify that I attended the deceased from Dec 10, 1955, to Feb 17, 1958 that I last saw the deceased alive on Feb 17, 1958 and that death occurred at 5:30 P.M. from the cause and on the date stated above.

ACTUAL SIGNATURE W. W. Elgin M.D. ADDRESS (Street, city or town, state) Sheppard Pratt Hosp. Pk 18, 1953 DATE SIGNED  
PHYSICIAN'S NAME (Type) W. W. Elgin Towson - 4. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2/18/58	22c. NAME OF CEMETERY OR CREMATORY Bunnell	22d. LOCATION (City, town, or county) (State) Frankford, Indiana
23. FUNERAL DIRECTOR'S SIGNATURE Wm Indickor Wm Nels Belloir, Ind		ADDRESS	24a. REC'D BY REGISTRAR DATE FEB 21 '58
			24b. REGISTRAR'S SIGNATURE W. Beach

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the results prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
ISM 9/SS

RECEIVED

01685

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE <b>MD.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO.</b> <b>3V014</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>HOUSE IN THE PINES</b> <b>16 FUSTING AVE</b>		d. STREET ADDRESS <b>621 GRANTLEY ST.</b> • IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EFFIE</b> First <b>I. MURRAY</b> Middle <b>L.</b> Last		4. DATE OF DEATH <b>FEB.</b> Month <b>8</b> Day <b>1958</b> Year	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG. 1, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED PRINCIPAL, BALTO. CITY SCHOOLS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JESSE H. MURRAY</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA TRACEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		17. INFORMANT <b>MRS. RUTH M. THOMPSON</b> Address <b>621 GRANTLEY ST. BALTO. 29, MD.</b>	
16. SOCIAL SECURITY NO.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Degenerative Heart Dis 2052</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) <b>Marked</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1956</b> to <b>Feb 8 58</b> , that I last saw the deceased alive on <b>Feb 6 1958</b> , and that death occurred at <b>930 A.M.</b> , from the causes and on the date stated above		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd Catonsville 28 md</b> DATE SIGNED <b>8 Feb 1958</b>	
ACTUAL SIGNATURE <b>W.E. Mc Grath</b> M.D.		PHYSICIAN'S NAME (Type) <b>W.E. Mc Grath</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 11/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WITKE FUNERAL DIR. 4161 EDMONDSON AVE</b> ADDRESS		24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 12345

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
JAMES M. SMITH		45		M		W		JAN 15 1893		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD		MD	
MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY OF MARRIAGE		STATE OF MARRIAGE		COUNTRY OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JAN 15 1915		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD	
CAUSE OF DEATH		DISEASE		INJURY		POISON		OTHER		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
HEART DISEASE		CORONARY		ARTERIO		SCLEROSIS		OTHER		FEB 10 1938		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
FEB 10 1938		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
FEB 10 1938		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD		MD		FEB 10 1938		BALTIMORE		MD		MD	

RECEIVED  
FEB 13 1938  
BUREAU V. S.

## 1696 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6110 Edmondson Ave.</b>		d. STREET ADDRESS <b>6110 Edmondson Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>W.</b> Last <b>Newman</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Sweden</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>--- Berlin</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>--</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>John Bedford</b>		Address <b>6018 Edmondson Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardio-Vascular-Renal Disease</b> DUE TO (c) <b>Hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 days</b> <b>10 yrs</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1.5.48</b> 19 <b>58</b> , to <b>2.17.58</b> 19 <b>58</b> , that I last saw the deceased alive on <b>2/17/58</b> 19 <b>58</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George E. Urban</b>		ADDRESS (Street, city or town, state) <b>805 Fred Ave 28 Md.</b>	
PHYSICIAN'S NAME (Type) <b>George E. URBAN</b>		DATE SIGNED <b>2.17.58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-22-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home Catonsville Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Page One

1. NAME OF DECEASED [Faint text]		2. PLACE OF DEATH [Faint text]	
3. SEX [Faint text]		4. AGE [Faint text]	
5. OCCUPATION [Faint text]		6. CAUSE OF DEATH [Faint text]	
7. DATE OF DEATH [Faint text]		8. TIME OF DEATH [Faint text]	
9. PLACE OF BIRTH [Faint text]		10. DATE OF BIRTH [Faint text]	
11. NAME OF MOTHER [Faint text]		12. NAME OF FATHER [Faint text]	
13. MARITAL STATUS [Faint text]		14. EDUCATION [Faint text]	
15. RELIGION [Faint text]		16. RACE [Faint text]	
17. PREVIOUS ILLNESS [Faint text]		18. MEDICAL HISTORY [Faint text]	
19. SIGNATURE OF PHYSICIAN [Faint text]		20. SIGNATURE OF REGISTRAR [Faint text]	
21. DATE [Faint text]		22. PLACE [Faint text]	

BURMAN V. S.

FEB 24 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1697 CERTIFICATE OF DEATH

01687

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix P.O. Dance Mill</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Phoenix P.O. Dance Mill</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Longmore Circle</u>		d. STREET ADDRESS <u>Longmore Circle</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH.</u> Middle <u>C.</u> Last <u>NICHOLSON</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>23</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 17, 1919</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Pharo</u>		14. MOTHER'S MAIDEN NAME <u>Ellen May McDongall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>Npne</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Robert H. Nicholson</u>		Address <u>Phoenix, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Breast, metastatic</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> 19 <u>57</u> , to <u>present</u> , that I last saw the deceased alive on <u>Feb 22</u> , 19 <u>58</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel Bakal</u> M.D.		ADDRESS (Street, city or town, state) <u>3600 Lochearn Dr.</u> DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>DANIEL BAKAL, MD</u>		<u>Balto - 7, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>Feb. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons, Towson, Maryland</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>FEB 25 '58</u>	24b. REGISTRAR'S SIGNATURE <u></u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is partially filled out with handwritten text.

NAME OF DECEASED: [Handwritten Name]

DATE OF DEATH: [Handwritten Date]

PLACE OF DEATH: [Handwritten Location]

CAUSE OF DEATH: [Handwritten Cause]

REPORTED BY: [Handwritten Name]

SIGNATURE OF PHYSICIAN: [Handwritten Signature]

DATE OF REPORT: [Handwritten Date]

PLACE OF REPORT: [Handwritten Location]

REMARKS: [Handwritten Remarks]

BUREAU V. S.

FEB 25 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1698

## CERTIFICATE OF DEATH

Reg. Dist. No.

01688

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>105 Homberg Avenue</u>		d. STREET ADDRESS <u>1 105 Homberg Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>L.</u> Last <u>Palmer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>25th</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1888</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Crook</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. James Beardsley,</u> Address <u>105 Homberg Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diagnosed Anteroseptal</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260X Diabetes mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> 19 <u>56</u> to <u>Feb</u> 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 2</u> 19 <u>58</u> , and that death occurred at <u>1145A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert J. Lyden</u> M.D.		ADDRESS (Street, city or town, state) <u>815 Eastern Ave, Balt 21, Md</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT J. LYDEN, M.D.</u>		DATE SIGNED <u>2/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/28/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u> ADDRESS <u>5305 Harford Road #14</u>		24a. REC'D BY REGISTRAR <u>Feb 28 '58</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON TO  
CERTIFICATE OF DEATH

RECEIVED  
FEB 28 1953  
BUREAU V. A.



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01689

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>51</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1105 Courtney Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Elizabeth Virginia Parkinson</b>		4. DATE OF DEATH <b>Feb. 8, 1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1912</b>
9. AGE (In years - last birthday) <b>45 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unemployed</b>	
11. BIRTHPLACE (State or foreign country) <b>Stevensville Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13. FATHER'S NAME <b>John L. XXXXX Ozman</b>		14. MOTHER'S MAIDEN NAME <b>Irene V. Spilker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-12-2158</b>	
17. INFORMANT <b>Clarence B. Ozman</b>		Address <b>1105 Courtney Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> <b>Acute Cardiac Failure.</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Cardiovascular Disease</b> (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. McKieffer</b>		DATE SIGNED <b>Feb. 8, 58</b>	
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-11-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Stevensville</b>	22d. LOCATION (City, town, or county) (State) <b>Stevensville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard, 4107 Wilkens Ave.</b>		24a. REC'D BY REGISTRAR <b>FEB 11 '58</b> 24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH

MISSISSIPPI STATE DEPARTMENT OF HEALTH—BANKRUPTCY  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1933

RECEIVED

Howards H. Hubbard, 1101 Wilkins Ave.  
Baptist 2-11-33  
Beverlyville

## 1699 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1yr7mths19days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		d. STREET ADDRESS <b>180 Eutaw Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Irene</b> Middle <b>Bean</b> Last <b>Parks</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> , Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 15, 1890</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles Bean</b>		14. MOTHER'S MAIDEN NAME <b>Francis Woods</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-14-0887</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 7, 1957</b> , to <b>Feb. 11, 1958</b> , that I last saw the deceased alive on <b>Feb. 11, 1958</b> , and that death occurred at <b>2:30p</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachsler</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>2-11-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M.D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>2/14/58</b>	<b>Cathedral</b>	<b>4300 Oak Linden Rd</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Fahy &amp; Son</b>		ADDRESS <b>1318 Light</b>	
24a. REC'D BY REGISTRAR <b>FEB 16 58</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. ST

FEB 18 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1700

## CERTIFICATE OF DEATH

Reg. Dist. No.

02975

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>				c. LENGTH OF STAY IN 1b <b>110 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>824N. Washington Street</b>			
3. NAME OF DECEASED (Type or print) <b>Also: (JAMES First A. Middle PADEN) Last JAMES A. PAYTON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 11, 1893</b>		9. AGE (In years last birthday) yrs. <b>64</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder - acetylene</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel Company</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Alfred Paden</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>443x</b> DUE TO <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b> <b>5 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CEREBRAL THROMBOSIS, DUE TO ARTERIOSCLEROSIS, LEFT MIDDLE CEREBRAL ARTERY * Duration 6 MONTHS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 7, 1957</b> to <b>February 25, 1958</b> and that death occurred at <b>10:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VA HOSPITAL, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/25/58</b> ACTUAL SIGNATURE <b>Paul F. Richardson</b> M.D. PHYSICIAN'S NAME (Type) <b>PAUL F. RICHARDSON, Chief, Physical Medicine and Rehabilitation Service</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery, Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy O. Wilson Funeral Home, 2004 Orleans St. Baltimore, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 14 '58</b>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BUREAU V. S.

MAR 17 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01691

Reg. Dist. No.

1701

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1203 Glenback Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Chenoweth</b> Last <b>Pearce</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>23,</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1879</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William H. Chenoweth</b>		14. MOTHER'S MAIDEN NAME <b>Katharine Frock</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Donald E. Pearce</b>		Address <b>Pikesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary occlusion</b> DUE TO (c) <b>Art. Sclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 days.</b> <b>18 days.</b> <b>5 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 1957</b> to <b>Feb. 23, 1958</b> , that I last saw the deceased alive on <b>February 22, 1958</b> , and that death occurred at <b>2:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James A. Miller</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1331 Reister Rd., Pikesville, Md. 2/24/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James A. Miller</b>		<b>Pikesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 26, 58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Saters Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Falls Rd. Balto. Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>DATE</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

FEB 26 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01692

1792

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>		c. LENGTH OF STAY IN 1b <i>In transit</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i> ✓		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Reisterstown Road.</i>			d. STREET ADDRESS <i>Route 1</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Lee</i> Last <i>Powder</i>			4. DATE OF DEATH Month <i>Feb.</i> Day <i>16,</i> Year <i>19 58</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 24, 1942</i>	9. AGE (In years last birthday) <i>15</i> yrs.	IF UNDER 1 YEAR Months <i>15</i> Days <i>15</i> Hours <i>15</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School student</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			13. FATHER'S NAME <i>William Powder</i>		
14. MOTHER'S MAIDEN NAME <i>Hester M. Edmondson</i>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>None</i> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <i>None</i>			17. INFORMANT Address <i>Hester M. Powder, Sykesville, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia due to Carbon monoxide</i> <i>891.5</i> DUE TO <i>Poisoning</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>12 hrs.</i> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Sat in car in snow drift - motor running over night</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>7:15</i> p. m. <i>Feb 15 1958</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Route 91 (Md)</i>	20f. (City or town) <i>Finksburg</i>	(County) <i>Carroll</i>	(State) <i>Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>D.D. Catles</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>2-17-58</i>	
EXAMINER'S NAME (Type) <i>D. D. CATLES</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>2-21-1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Providence</i>	22d. LOCATION (City, town, or county) <i>Gamber</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C.M. Waetz</i>		ADDRESS <i>Winfield Md.</i>		24a. REC'D BY REGISTRAR <i>DATE FEB 21 '58</i>	24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MISSISSIPPI  
DEPARTMENT OF HEALTH - BIRMINGHAM  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

LOCALITY

CITY

COUNTY

STATE

ZIP

DEATH CERTIFICATE NO.

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

NAME OF EXAMINER

DEGREE

BOARD

EXPIRATION DATE

REMARKS

CAUSE OF DEATH

MANNER OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

PRE-EXISTING DISEASE

POST-MORTEM

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BUREAU V. S.

FEB 21 1959

RECEIVED



CERTIFICATE OF DEATH

Reg. Dist. No.

01693

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrow Pt</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrow Point</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1020 J St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Blanche E.</u> Middle <u>Prather</u> Last <u>Prather</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>16</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 30, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baldy, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baldy, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>George W. Prather</u>		14. MOTHER'S MAIDEN NAME <u>Emma E. Latimore</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>32-22 Union St. Flushing, N.Y.</u>	
17. INFORMANT <u>Robert Green</u>		Address <u>32-22 Union St. Flushing, N.Y.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Feb.</u> Day <u>16</u> Year <u>1958</u> Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 13, 1958</u> to <u>Feb 16, 1958</u> , that I last saw the deceased alive on <u>February 16, 1958</u> , and that death occurred at <u>2 P.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J.H. Thomas</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>107 N. Main St. Baltimore 22 Md. 2/18/58</u>	
PHYSICIAN'S NAME (Type) <u>J.H. Thomas</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 21, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem</u>	22d. LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph T. Ellickson</u>		ADDRESS <u>1129 N. Carbon</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>DATE</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1794 CERTIFICATE OF DEATH

01694  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKDALE</u>		c. LENGTH OF STAY IN 1b <u>38 YRS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3207 MAYFIELD AVE</u>		d. STREET ADDRESS <u>3207 MAYFIELD AVE 7</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KATHERINE</u> Middle <u>MAY</u> Last <u>QUAIA</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 20 1876</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	11. IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>FRANCES DAVIS</u>		14. MOTHER'S MAIDEN NAME <u>? HARLOW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-22-2796</u>	
17. INFORMANT <u>MR WESLEY QUAIN</u>		Address <u>3207 MAYFIELD AVE 7-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE HEART FAILURE</u> DUE TO <u>PULMONARY EDEMA + KIDNEY FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PULMONARY TUBERCULOSIS</u> DUE TO <u>—</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY -</u> <u>3 YEARS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>JUNE 1</u> , 19 <u>57</u> , to <u>FEB - 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB - 4</u> , 19 <u>58</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas E. Wheeler</u>		ADDRESS (Street, city or town, state) <u>3601 CHEMAR RD BALTO 7 - MD</u>	
PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER</u>		DATE SIGNED <u>2/14/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/7/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>		ADDRESS <u>4600 Liberty Hghts. Ave.</u>	
24a. REC'D BY REGISTRAR <u>FEB 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1705 CERTIFICATE OF DEATH

01695

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Hillside Avenue</b>				d. STREET ADDRESS <b>Hillside Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>AGNES CATHERINE RAFFERTY</b>				4. DATE OF DEATH Month Day Year <b>February 5, 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 18, 1903</b>		9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmistress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Post Office</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James F. Rafferty</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Riley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Family records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bacterial Endocarditis</b> <b>430.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Streptococcus Viridans</b> DUE TO (c) <b>Chr. Glomerulonephritis &amp; Uremia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>5 yrs.</b> <b>3 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Septic infarction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	Month, Day, Year <b>19 58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>19 38</b> to <b>2-5-</b> <b>19 58</b> , that I last saw the deceased alive on <b>2-5-</b> <b>19 58</b> , and that death occurred at <b>3:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>3105 N. Charles St. Baltimore, 18.</b> DATE SIGNED <b>2-5-58</b>							
ACTUAL SIGNATURE <b>Robert H. Silver</b>		M.D. <b>3105 N. Charles St. Baltimore, 18.</b>					
PHYSICIAN'S NAME (Type) <b>R. H. Silver</b>		DATE <b>Feb 7 1958</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Texas, Baltimore Co., Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons</b>			ADDRESS <b>Towson, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 7 1958</b>		24b. REGISTRAR'S SIGNATURE <b>DeL...</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

REG. NO. 111

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65	
DATE OF DEATH February 7, 1958		PLACE OF DEATH Home		CITY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 111	
DATE OF BIRTH January 1, 1893		PLACE OF BIRTH Maryland		CITY Baltimore	
FATHER'S NAME John H. Harris		MOTHER'S NAME Mary E. Harris		CITY Baltimore	
OCCUPATION Retired		EDUCATION High School		RELIGION Roman Catholic	
MARITAL STATUS Married		SPOUSE'S NAME Elizabeth Harris		CITY Baltimore	
DATE OF MARRIAGE June 15, 1915		PLACE OF MARRIAGE Baltimore		CITY Baltimore	
DATE OF INTERVIEW February 10, 1958		INTERVIEWER J. H. Harris		CITY Baltimore	

NAME OF PHYSICIAN Dr. J. H. Harris		ADDRESS 1234 Main St.		CITY Baltimore	
NAME OF HOSPITAL St. Mary's Hospital		ADDRESS 5678 Park Ave.		CITY Baltimore	
NAME OF NURSE Mrs. J. H. Harris		ADDRESS 9010 Elm St.		CITY Baltimore	
NAME OF FUNERAL HOME The Funeral Home		ADDRESS 1111 Broadway		CITY Baltimore	
NAME OF MINISTER Rev. J. H. Harris		ADDRESS 2222 Church St.		CITY Baltimore	
NAME OF CLERGYMAN Rev. J. H. Harris		ADDRESS 3333 School St.		CITY Baltimore	
NAME OF CHURCH St. Mary's Church		ADDRESS 4444 Market St.		CITY Baltimore	
NAME OF BURIAL PLACE St. Mary's Cemetery		ADDRESS 5555 Center St.		CITY Baltimore	
NAME OF CEMETERY St. Mary's Cemetery		ADDRESS 6666 Division St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 7777 Union St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 8888 Madison St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 9999 Washington St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 10101 Pennsylvania St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 11111 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 12121 New Jersey St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 13131 New Mexico St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 14141 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 15151 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 16161 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 17171 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 18181 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 19191 New York St.		CITY Baltimore	
NAME OF INTERVIEWER J. H. Harris		ADDRESS 20201 New York St.		CITY Baltimore	

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FEB 7 1958

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 20 Film 225 2-19-58 ams

1706

# CERTIFICATE OF DEATH

01696

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>608 Highland Ave.</b>		d. STREET ADDRESS <b>1 608 Highland Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>J.</b> Last <b>RAPHEL, Sr.</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>5,</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 14, 1884</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Title Searcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Title Searcher</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Fressenjas Raphael</b>		14. MOTHER'S MAIDEN NAME <b>Jeanette Braden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-07-3762A</b>	
17. INFORMANT <b>Mr. Gus Muller - 2130 Fair Lane Towson 4, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>902.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial (Hypostatic) Pneumonia 1 wk.</b> DUE TO (c) <b>Fractured Rt Hip</b> 2 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Fell while getting into chair</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>10:30 p. m.</b> Jan. 20 19 <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Towson Balto. Maryland</b>	
21. I certify that I attended the deceased from <b>May 19 48</b> to <b>Feb 5, 19 58</b> , that I last saw the deceased alive on <b>Feb 13, 19 58</b> , and that death occurred at <b>11:15 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7501 York Rd. Towson 4, Md.</b> DATE SIGNED <b>2/6/58</b>			
ACTUAL SIGNATURE <b>Charles F. O'Donnell</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles F. O'Donnell M.D. Towson 4, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Stephen Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bradshaw, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Am. J. Sicker &amp; Sons - Balto 17, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 10 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Dee Leach</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1707 CERTIFICATE OF DEATH

Reg. Dist. No. 01697

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>2 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1555 Clifton Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>GRIFFIN</b> Middle <b>---</b> Last <b>RAWLINGS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 19, 1891</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Private Family</b>	
11. BIRTHPLACE (State or foreign country) <b>Calvert County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Benson Rawlings</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Coates</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EDEMA, CONGESTION AND BRONCHO PNEUMONIA</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>HYPERTENSIVE CARDIO VASCULAR DISEASE.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 Weeks</b> <b>Unknown.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 3, 1958</b> , to <b>February 5, 1958</b> and that death occurred at <b>9:10 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>VA HOSPITAL, FORT HOWARD, MARYLAND 2/6/58</b>			
ACTUAL SIGNATURE <b>Chien Wei Lan</b>		M.D. <b>VAH, FT. HOWARD, MARYLAND</b>	
PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel W. Sullivan, 1011 N. Arlington Ave., Balto.</b>		24a. REC'D BY REGISTRAR <b>FEB 10 1958</b>	
ADDRESS <b>#17, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Overhach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 111

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Date of Death		Time of Death		Place of Death	
John Doe		Male		45		October 15, 1905		Maryland		1234 Main Street		Heart Disease		October 20, 1950		10:00 AM		Home	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Coroner		Signature of Burial Officer		Signature of Undertaker		Signature of Mortician		Signature of Embalmer		Signature of Funeral Home		Signature of Cemetery	
John Doe, M.D.		Jane Smith, R.		John Doe, Jr.		John Doe, Sr.		John Doe, Sr.		John Doe, Sr.		John Doe, Sr.		John Doe, Sr.		John Doe, Sr.		John Doe, Sr.	

BUREAU V. S.

FEB 10 1953

RECEIVED



1708

# CERTIFICATE OF DEATH

01698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. LENGTH OF STAY IN 1b <b>6</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7904 30th Street</b>		d. STREET ADDRESS <b>7904 30th Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Thomas</b> Last <b>Rhodes</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 31, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>(ret'd) Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal mines</b>	11. BIRTHPLACE (State or foreign country) <b>Swanton, Maryland</b>
13. FATHER'S NAME <b>Theodore Rhodes</b>		14. MOTHER'S MAIDEN NAME <b>Mary (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>493X</b>	
17. INFORMANT <b>Mrs. Geraldine Shirley</b>		Address <b>7904 30th Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac De compensation</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pneumonia</b> DUE TO (c) <b>Bilateral pulmonary Tuberculosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>493X</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 21</b> , 19 <b>58</b> , to <b>Feb 24</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 24</b> , 19 <b>58</b> , and that death occurred at <b>9:40 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles C MacMinn</b>		ADDRESS (Street, city or town, state) <b>2900 E Baltimore St</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>CHARLES C MAC MINN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	22b. DATE THEREOF <b>2-26-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Nethon Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Elk Garden, West Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. L. ...</b>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





CERTIFICATE OF DEATH

FILE NO. 100-100000

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH	
JAMES EARL RAY		35		M		W		4/4/68	
PLACE OF DEATH		CITY		COUNTY		STATE		ZIP	
BALTIMORE		BALTIMORE		BALTIMORE		MARYLAND		21201	
OCCUPATION		PROFESSION		EDUCATION		RELIGION		MARRIAGE	
FARMER		HIGH SCHOOL		METHODIST		MARRIED		1965	
CAUSE OF DEATH		MANNER OF DEATH		TOXICOLOGY		AUTOPSY		CORONER	
HEART DISEASE		NATURAL		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE	
4/4/68		4/4/68		4/4/68		4/4/68		4/4/68	

RECEIVED  
FEB 5 1968  
BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 Filmg225 2-13-58 et

## CERTIFICATE OF DEATH

01719

Reg. Dist. No. ....

## 1. PLACE OF DEATH

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

Upper Falls

LENGTH OF STAY (in this place)

14 Yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Franklinville Rd.

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Balto:

CITY (If outside corporate limits, write RURAL and give nearest town)

Upper Falls

STREET ADDRESS

Franklinville Rd.

## 3. NAME OF DECEASED (Type or Print)

James

Francis

Smith

## 4. DATE OF DEATH

(Month)

(Day)

(Year)

Feb.

4

19 58

## 5. SEX

M

## 6. COLOR OR RACE

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Single

## 8. DATE OF BIRTH

Sept. 21, 1923

## 9. AGE last birthday

34 yrs.

## IF UNDER 1 YEAR

Months

Days

## IF UNDER 24 HRS.

Hours

Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Plumber

## 10b. KIND OF BUSINESS OR INDUSTRY

Construction

## 11. BIRTHPLACE (State or foreign country)

Fallston, Maryland

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Warren Kemper Smith

## 14. MOTHER'S MAIDEN NAME

Anna Regina Shanahan

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

yes

World War II

## 16. SOCIAL SECURITY NO.

219-18-0577

## 17. INFORMANT &amp; ADDRESS

Warren Kemper Smith Jr.-Chapman Rd.

Upper Falls, Balto, Md.

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE (A)

(A)

Coronary occlusion

## INTERVAL BETWEEN ONSET AND DEATH

4 hrs.

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)

## 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

## 21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21a. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb., 1958, to Feb. 4, 1958, that I last saw the deceased alive on Feb. 4, 1958, and that death occurred at 4:45 M, from the causes and on the date stated above.

## SIGNATURE

William A. Tyson M.D.

## ADDRESS (Street, city, town, state)

Kingsville Md

## DATE SIGNED

2-4-58

## 23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

## DATE THEREOF

2/8/58

## NAME OF CEMETERY OR CREMATORY

St John's-Long Green

## LOCATION (City, town, or county)

Balto:Co:Md.

(State)

## 24. REC'D BY REGISTRAR

## REGISTRAR'S SIGNATURE

## 25. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

DATE FEB 7 '58

[Signature]

George J. Ruth, Inc., -1735 Harford Avenue Balto: Md.



# CERTIFICATE OF DEATH

Has Died

1. DECEASED'S NAME (Last, first, middle)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. PLACE OF BIRTH (City, State, Country)

5. DATE OF DEATH (Month, Day, Year)

6. TIME OF DEATH (Hour, Minute)

7. CAUSE OF DEATH (Immediate Cause)

8. MANNER OF DEATH (Natural, Accidental, Homicide, Suicide)

9. SIGNATURE OF PHYSICIAN (Name, Title, Address)

10. SIGNATURE OF REGISTRAR (Name, Title, Address)

11. SIGNATURE OF WITNESSES (Name, Title, Address)

12. SIGNATURE OF DECEASED (Name, Title, Address)

13. SIGNATURE OF DECEASED'S NEXT OF KIN (Name, Title, Address)

14. SIGNATURE OF DECEASED'S ATTORNEY (Name, Title, Address)

15. SIGNATURE OF DECEASED'S MINISTER (Name, Title, Address)

16. SIGNATURE OF DECEASED'S CHURCH (Name, Title, Address)

17. SIGNATURE OF DECEASED'S FUNERAL HOME (Name, Title, Address)

18. SIGNATURE OF DECEASED'S BURIAL PLACE (Name, Title, Address)

19. SIGNATURE OF DECEASED'S CEMETERY (Name, Title, Address)

20. SIGNATURE OF DECEASED'S INTERMENT (Name, Title, Address)

21. SIGNATURE OF DECEASED'S CREMATION (Name, Title, Address)

22. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

23. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

24. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

25. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

26. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

27. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

28. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

29. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

30. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

31. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

32. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

33. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

34. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

35. SIGNATURE OF DECEASED'S OTHER (Name, Title, Address)

BUREAU V. 2

FEB 7 1938

RECEIVED

St. John's - John Green

2/7/38

1001

RECEIVED

1711  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>3mos</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>69 Hanover Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>J</u> Last <u>Rinehart</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>4</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept, 23, 1883</u>
9. AGE (In years last birthday) <u>84 yrs.</u>		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>19</u> Hours <u>58</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>self</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>	
13. FATHER'S NAME <u>Jonas Rinehart</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. John D. Spangler</u>		Address <u>69 Hanover Rd. Reisterstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic C.-V. Disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>none</u> DUE TO (c) <u>none</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>none</u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>	20f. (City or town) (County) (State) <u>none</u>
21. I certify that I attended the deceased from <u>10-16-55</u> , 19 <u>55</u> , to <u>2-4-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-3-58</u> , 19 <u>58</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. D. Caples</u>		ADDRESS (Street, city or town, state) <u>6 Hanover Rd.</u> DATE SIGNED <u>2-4-58</u>	
PHYSICIAN'S NAME (Type) <u>D. D. Caples, M. D.</u>		<u>Reisterstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb. 6, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Piney Creek Brethren</u>	22d. LOCATION (City, town, or county) (State) <u>Taneytown, Rural Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Zuss</u>		ADDRESS <u>Taneytown, Md.</u>	
24a. REC'D BY REGISTRAR <u>W. H. Leach</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Death	
Place of Birth		Usual Residence		Cause of Death		Manner of Death	
Occupation		Education		Medical History		Post-mortem Examination	
Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness	

BUREAU V. 2

1936 6 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## 1711 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01701

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gwynn Lake</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Gwynn Lake</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7 Summerfield Rd.</b>		d. STREET ADDRESS <b>7 Summerfield Rd. #7</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MACK</b> Middle Last <b>ROE</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>9,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1897</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edward Roe</b>		14. MOTHER'S MAIDEN NAME <b>Caroline -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-9912</b>	
17. INFORMANT <b>Mrs. Jane Roe</b>		Address <b>7 Summerfield Rd. Balto. 7,</b>	
18. CAUSE OF DEATH [Enter only one cause prevailing for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of stomach</b> DUE TO (c) <b>1 year</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 18, 1953</b> , to <b>Feb 9, 1958</b> , that I last saw the deceased alive on <b>Jan 23, 1958</b> , and that death occurred at <b>10:50</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Grabill</b>		ADDRESS (Street, city or town, state) <b>1945 W. Balto. St. #23</b>	
DATE SIGNED <b>2-11-58</b>			
PHYSICIAN'S NAME (Type) <b>James R. Grabill, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Millville, N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Lickner &amp; Sons - Balto. 17, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>			

CERTIFICATE OF DEATH

Page One of Two

Form with multiple fields for death certificate data, including name, date, and cause of death. The text is mostly illegible due to blurriness.

BUREAU V. S.

FEB 13 1958

RECEIVED



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G226 3-7-58 et

01702

1712

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> <u>3V01.4</u> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Towson Home (Nursing)</u>				d. STREET ADDRESS <u>3113 Virginia Avenue</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elsie M. Rountree</u>				4. DATE OF DEATH Month <u>2/24</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1899</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Easton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Cavalier</u>				14. MOTHER'S MAIDEN NAME <u>Annie Jester</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>*****</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss. Ann E. Rountree 3113 Virginia Ave Zone 15</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1 Congestive Heart Failure</u> DUE TO <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD</u> DUE TO (c) <u>ASCVD</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Polyglycemia Vera</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 16</u> , 19 <u>58</u> , to <u>Feb 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 23</u> , 19 <u>58</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>George H. Beck</u>				ADDRESS (Street, city or town, state) <u>6012 Hybrid Road Baltimore, Md.</u>			
PHYSICIAN'S NAME (Type) _____				DATE SIGNED _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-26-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D Loring Byers</u>				ADDRESS <u>5005 Park Heights Ave. Balto 15</u>		24a. REC'D BY REGISTRAR <u>W. H. Lewis</u>	
				DATE <u>FEB 28 '58</u>			

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		JAN 5 1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
1000 1/2 N. W. 10th St., Baltimore, Md.		Author		High School		Married		JAN 30 1968		BALTIMORE, MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTRATION NO.		DATE OF REGISTRATION		PLACE OF REGISTRATION	
HEART DISEASE		NATURAL		1000		1000		JAN 30 1968		BALTIMORE, MARYLAND	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE		DATE		DATE		DATE		DATE		DATE	
JAN 30 1968		JAN 30 1968		JAN 30 1968		JAN 30 1968		JAN 30 1968		JAN 30 1968	

BUREAU V. 81

FEB 28 1968

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01703

1713

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3203 Willoughby Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mrs. Edith M.</u> Middle <u>Ruth</u> Last <u>Ruth</u>		4. DATE OF DEATH Month <u>February</u> Day <u>3rd</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Perry County, Penna</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Yocum</u>		14. MOTHER'S MAIDEN NAME <u>Daisy M. Wampler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>196-10-45684</u>	
17. INFORMANT Address <u>Mr. Philip C. Ruth, 3203 Willoughby</u>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Hypertensive Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>several years</u> (c) <u>several years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1957, to 3 Feb, 1958, that I last saw the deceased alive on 31 Jan, 1958, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas J. Brennan M.D. ADDRESS (Street, city or town, state) 5217 Harford Road Balto 14 Md. DATE SIGNED 2/3/58

PHYSICIAN'S NAME (Type) Thomas J. Brennan Baltimore, 14, Md.

22a. BURIAL, CREMATION, REINMENT (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/6/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mennonite Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Millersville, Pennsylvania</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck Inc.</u> ADDRESS <u>5305 Harford Road.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01704

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Road</u>		d. STREET ADDRESS <u>Chapel Rd</u>	
3. NAME OF DECEASED (Type or print) <u>George H. Rye</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 15 1917</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Law Enforcement</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Leonard Rye</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Dietz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>244-14-4543</u>	
17. INFORMANT <u>Mr. Estella Rye</u>		Address <u>4227 Chapel Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4-20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Unk - History of Tachycardia ?</u> <u>Unk</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Possible Aspiration Vomitus None Known</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>	
20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>		20b. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>19</u>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20e. (City or town) <u>  </u>		20f. (County) <u>  </u> (State) <u>  </u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank T. Kasik, Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK, JR.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Feb 15 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-19-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Luth. Cem</u>		22d. LOCATION (City, town, or county) <u>Baltimore - Md.</u> (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Luxahy Fun'l Home</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>FEB 19 58</u>	
ADDRESS <u>7401 Belair Rd.</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK  
DEPARTMENT OF HEALTH

RECEIVED  
FEB 19 1938  
BUREAU V. S.

## 1715 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chase</b>			c. LENGTH OF STAY IN 1b <b>Chase</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>William</b> Last <b>Schatz</b>			4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Jan. 1884</b>		9. AGE (In years last birthday) yrs. <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Henry Schatz</b>			14. MOTHER'S MAIDEN NAME <b>Sarah Mentley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-- -- --</b>	17. INFORMANT <b>Norman Schatz</b> Address <b>Chase, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho-Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>					INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Nov. 29</b> , 19 <b>57</b> , to <b>Febr. 20</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Febr. 20</b> , 19 <b>58</b> , and that death occurred at <b>7:10 P</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>Joseph Miceli</i>		M.D. <b>108 S. Taylor Avenue</b>		DATE SIGNED <b>2/21/58</b>	
PHYSICIAN'S NAME (Type) <b>Joseph Miceli, M.D.</b>		<b>Baltimore 21, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/24/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Tarring</i>		ADDRESS <i>Aberdeen, Md.</i>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 1958</b>	24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Full Name		Sex		Age	
John William		Male		25	
Date of Birth		Place of Birth		Cause of Death	
Jan 15, 1908		Maryland		Heart Disease	
Date of Death		Place of Death		Occupation	
Jan 20, 1933		Baltimore, Md.		Teacher	
Time of Death		Physician		Burial Place	
10:00 AM		Dr. J. H. Smith		St. Mary's Cemetery	
Signature of Physician		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]	

BUREAU V. S.

FEB 26 1933

RECEIVED

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oaklee Balto. 29, Md</b> c. LENGTH OF STAY IN 1b <b>1716</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Oaklee, Balto. 29 Md</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>922 Leeds Ave</b>		d. STREET ADDRESS <b>922 Leeds Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Agnes</b> Middle <b>O. Schermerhorn</b> Last 4. DATE OF DEATH Month <b>Feb.</b> Day <b>26</b> Year <b>1958</b>		5. SEX <b>Fem</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Oct. 26, 1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mgf.</b>	
11. BIRTHPLACE (State or foreign country) <b>Troy, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A</b>	
13. FATHER'S NAME <b>Fred. Shultis</b>		14. MOTHER'S MAIDEN NAME <b>Mary Call</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO. <b>214-01-5560</b>	
17. INFORMANT <b>Nelson W. Schermerhorn</b>		Address <b>1018 Leeds Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>903.5</b> DUE TO <b>Coronary Thrombosis</b> Cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Fracture of Right Hip</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of Right Hip</b>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on side walk while mailing a letter, foot caught in wire</b>	
20c. TIME OF INJURY Month, Day, Year <b>Feb. 20, 1958 12-30-57</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Public street</b>	
20f. (City or town) <b>Oaklee</b>		20g. (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Geo. S. M. Kieffer</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Geo. S. M. Kieffer M. D.</b>		DATE SIGNED <b>Feb. 26. 58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-1-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 3 '58</b>	
ADDRESS <b>4107 W. Pennsylvania Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
HEALTH DEPT.

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MAR 3 1938  
BUREAU V. 3

RECEIVED  
MAR 3 1938  
BUREAU V. 3

London Park 5-1-38



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01707

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Saytr Hill</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Saytr Hill</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8941 Saytr Hill RD</b>				1. d. STREET ADDRESS <b>8941 Saytr Hill Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>FREDERICK</b> First <b>SCHMIDT</b> Middle Last				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 3, 1867</b>		9. AGE (in years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SENIOR ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MU. WASTE CO.</b>		11. BIRTHPLACE (State or foreign country) <b>HOLLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UN KNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UN KNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>FREDERICK SCHMIDT JR. 8837 Victory Ave</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> <b>490X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an <b>Autopsy</b> <input checked="" type="checkbox"/> Partial <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William V. Lovitt, Jr.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		<b>2/13/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Trinity Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles H. Gaus</b>				ADDRESS <b>San 8802 Harbor Rd</b>		24a. REC'D BY REGISTRAR <b>FEB 18 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FEB 18 1958

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*William J. Smith*

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF MEDICAL EXAMINER: [illegible]  
DATE OF EXAMINATION: [illegible]

-1554  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>40 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1020 Leeds Ave</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN HENRY SCHWARTZ</b>		4. DATE OF DEATH <b>2-16-58</b> 19 <b>19</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O RR</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Charles Schwartz</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Raver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>213-01-6220A</b>	
17. INFORMANT <b>Mary R. Schwartz, 1020 Leeds Ave.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic C-V Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchiectasis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>8 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1, 1953</b> to <b>2-16, 1958</b> , that I last saw the deceased alive on <b>2-13, 1958</b> , and that death occurred at <b>12:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James R. Grabill, M.D.</b>		ADDRESS (Street, city or town, state) <b>1945 W. Balto St.</b>	
PHYSICIAN'S NAME (Type) <b>James R. Grabill, M.D.</b>		DATE SIGNED <b>Balto 23, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-21-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine</b>	22d. LOCATION (City, town, or county) (State) <b>Balto, County</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>FEB 24 '58</b>	
ADDRESS <b>4107 Wilkens Ave</b>		24b. REGISTRAR'S SIGNATURE <b>Hubbard</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12  
 CERTIFICATE OF DEATH

NAME OF DECEASED JOHN HENRY JONAS		AGE 50 YRS	SEX MALE
RESIDENCE 1000 E. BROAD AVE		CITY BALTIMORE	
DATE OF DEATH FEB 24 1938		PLACE OF DEATH HOME	
CAUSE OF DEATH CORONARY THROMBOSIS		MANNER OF DEATH NATURAL	
SIGNATURE OF PHYSICIAN J. H. JONAS		SIGNATURE OF WITNESSES J. H. JONAS	

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FEB 24 1938

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 FEB 24 1938  
 BALTIMORE, MARYLAND  
 DEPARTMENT OF HEALTH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1718 CERTIFICATE OF DEATH

01709

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN 1b <b>8 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The House in the Pines 16 Rusting Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>S.</b> Last <b>Scott</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 6, 1871</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>	
13. FATHER'S NAME <b>Hugh B. Scott</b>				14. MOTHER'S MAIDEN NAME <b>Mary Jane Smythe</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT Address <b>Mrs. Mary S. Scott 3830 Reisterstown Road</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Decompensation</b> <b>450.0</b> DUE TO (b) <b>Generalized Atherosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b> <b>15 yr.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>6-21, 1957</b> , to <b>2-26, 1958</b> , that I last saw the deceased alive on <b>2-25, 1958</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wilmer K. Gollager</b>				ADDRESS (Street, city or town, state) <b>6209 Frederick Ave. Catonsville-28, Md.</b>			
DATE SIGNED <b>2-27-58</b>							
PHYSICIAN'S NAME (Type) <b>Wilmer K. Gollager</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 28, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stewartstown</b>		22d. LOCATION (City, town, or county) (State) <b>Stewartstown, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b> ADDRESS <b>3631 Falls Road</b>				24a. REC'D BY REGISTRAR <b>DATE FEB 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1719

## CERTIFICATE OF DEATH

01710

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u>				c. LENGTH OF STAY IN 1b <u>3 yrs.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lochearn</u>				d. STREET ADDRESS <u>13817 Cedar Dr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3817 Cedar Dr.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Lillian</u> Middle <u>May</u> Last <u>Scripture</u>				4. DATE OF DEATH Month <u>7</u> Day <u>9</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 30, 1886</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>		IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>New Hampshire</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles E. Carpenter</u>				14. MOTHER'S MAIDEN NAME <u>Emma H. Blodgett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no.</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>		17. INFORMANT <u>Charles Scripture, 3817 Cedar Dr. Baltimore 7 Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>none</u> DUE TO (c) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>8</u> Day <u>7</u> Year <u>1958</u> Hour <u>8</u> a. m. <u>30</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>508 Ristrictown Rd</u>	
20f. (City or town) <u>Pikesville 8 Md.</u>				20g. (County) <u>8 Md.</u>			
20h. (State) <u>8 Md.</u>							
21. I certify that I attended the deceased from <u>1958</u> , 19 <u>58</u> , to <u>9-7-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>8-7-58</u> , 19 <u>58</u> , and that death occurred at <u>4:55 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Paul H Royce</u>				DATE SIGNED <u>9-7-58</u>			
PHYSICIAN'S NAME (Type) <u>Paul H Royce M.D.</u>				<u>Pikesville 8 Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>				24a. REC'D BY REGISTRAR <u>W. H. H. H.</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	
ADDRESS <u>Ellsworth Armacost-4600 Liberty Hgts. Ave.</u>				DATE <u>FEB 11 '58</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
MARRIED		SINGLE		WIDOW		DIVORCED		SEPARATED		UNKNOWN		OTHER		REMARKS	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF BURIAL OFFICIAL		SIGNATURE OF OTHER	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY		REMARKS		REMARKS	

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FEB 11 1953  
BUREAU V. 3

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01711

1720

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> <u>CARNEY</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> <u>CARNEY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9823 Homeland</u>			e. STREET ADDRESS <u>9823 Homeland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>CHRISTIAN</u> Last <u>SENNHENN</u>			4. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1958</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 14 1874</u>		9. AGE (In years last birthday) <u>83</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>George Sennhenn</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Barnickol</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>Daughter</u> Address <u>9823 Homeland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>433.0</u> DUE TO <u>Adams's Stokes syn.</u> Conditions, if any, which gave rise to the immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> (c) <u>Age -</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank T. Kasik</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>Feb 19 1958</u>	
EXAMINER'S NAME (Type) <u>FRANK T. KASIK JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>2-21-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>	
22d. LOCATION (City, town, or county) <u>Balto Md</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans &amp; Son</u>		ADDRESS <u>8802 HARFORD RD</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 24 1958

BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE  
HEALTH DEPT.



MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

Page 1 of 1

Baltimore

Baltimore

Arduous

1410 Spring Spring Road

1410 Spring Spring Road

William M. Sewell

William M. Sewell

Male

Nov. 22, 1950

Colony, Md.

1410 Spring Spring Road

John E. Sewell

John E. Sewell

1410 Spring Spring Road

John E. Sewell

BUREAU V. E.

FEB 24 1958

RECEIVED

Baltimore Cemetery

2-15-58

Bureau

Howard H. Hubbard 1107 Wilkens Avenue

1721

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>25 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>MAX</u> Last <u>SHEA</u>		4. DATE OF DEATH Month <u>Febr.</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1872</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>85</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>YES</u>		13. FATHER'S NAME <u>Jos. ELDER</u>	
14. MOTHER'S MAIDEN NAME <u>Carmie Tilla</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>NONE</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Records of Spring Grove St. Hosp.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCL. C. ARDIO - V. A. S. C. D.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS, General, sev.</u> DUE TO (c) <u>Years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/1</u> 19 <u>54</u> , to <u>2/12</u> 19 <u>58</u> , that I last saw the deceased alive on <u>5/12/58</u> 19 <u>58</u> , and that death occurred at <u>6.10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Stella Wachslar</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp.</u> DATE SIGNED <u>2/12/58</u>	
PHYSICIAN'S NAME (Type) <u>STELLA WACHSLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2-15-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Geo L Schmitt</u> ADDRESS <u>2101 Frederick Ave</u>		24a. REC'D BY REGISTRAR <u>FEB 14 58</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Ch. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 14 1958

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1722 CERTIFICATE OF DEATH

Reg. Dist. No. 01714

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>52 Catonsville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 S. Prospect Ave.</b>				/ d. STREET ADDRESS <b>101 S. Prospect Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Gertrude A. Sheely</b>				4. DATE OF DEATH Month Day Year <b>February 7 1958</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 5, 1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Not Known</b>				14. MOTHER'S MAIDEN NAME <b>Not Known</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Jean McGlannan 408 Oak Court 28</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Congestive Heart Failure</b> DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ASCVD</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2.7 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Malignant Bladder (w/urinary)</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>11:30 AM 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/12, 1957</b> to <b>2/7, 1958</b> , that I last saw the deceased alive on <b>2/7, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Victor F. Long</b>				ADDRESS (Street, city or town, state) DATE SIGNED <b>715 Frederick Ave. Balt. 22 2/10/58</b>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-10-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Farley Funeral Home Catonsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 11 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

FEB 11 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1723 CERTIFICATE OF DEATH

Reg. Dist. No. 01715

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>				c. LENGTH OF STAY IN 1b <u>29 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgeway Manor</u>				d. STREET ADDRESS <u>203 Glenmore Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY-CATHERINE SHIPLEY</u>				4. DATE OF DEATH <u>Feb</u> <u>21</u> <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb-27-1869</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>William Schmeling</u>				14. MOTHER'S MAIDEN NAME <u>Barbara E. Yoe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Violet E. Nitzke</u> Address <u>203 Glenmore Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cerebrovascular disease</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> , to <u>Feb 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 15</u> , 19 <u>58</u> , and that death occurred at <u>8:45</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John A. Nesbitt Jr.</u> M.D. <u>1118 St. Paul St.</u> ADDRESS (Street, city or town, state) <u>Baltimore 2, Maryland</u>				DATE SIGNED <u>2-21-58</u>			
PHYSICIAN'S NAME (Type) <u>JOHN A. NESBITT, JR.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 24 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Connel</u> ADDRESS <u>5311 Edmondson Ave</u>				24a. REC'D BY REGISTRAR <u>FEB 24 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

CERTIFICATE OF DEATH

Form 10-1

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]		3. AGE [REDACTED]		4. DATE OF BIRTH [REDACTED]	
5. PLACE OF BIRTH [REDACTED]		6. OCCUPATION [REDACTED]		7. MARITAL STATUS [REDACTED]		8. COLOR [REDACTED]	
9. PLACE OF DEATH [REDACTED]		10. CAUSE OF DEATH [REDACTED]		11. MANNER OF DEATH [REDACTED]		12. DATE OF DEATH [REDACTED]	
13. SIGNATURE OF PHYSICIAN [REDACTED]		14. SIGNATURE OF DEATH REGISTRAR [REDACTED]		15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF DECEASED [REDACTED]	
17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF DECEASED [REDACTED]		19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF DECEASED [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF DECEASED [REDACTED]		23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF DECEASED [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF DECEASED [REDACTED]		27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF DECEASED [REDACTED]	
29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF DECEASED [REDACTED]		31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF DECEASED [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF DECEASED [REDACTED]		35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF DECEASED [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF DECEASED [REDACTED]		39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF DECEASED [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF DECEASED [REDACTED]		43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF DECEASED [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF DECEASED [REDACTED]		47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF DECEASED [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF DECEASED [REDACTED]		51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF DECEASED [REDACTED]	
53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF DECEASED [REDACTED]		55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF DECEASED [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF DECEASED [REDACTED]		59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF DECEASED [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF DECEASED [REDACTED]		63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF DECEASED [REDACTED]	
65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF DECEASED [REDACTED]		67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF DECEASED [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF DECEASED [REDACTED]		71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF DECEASED [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF DECEASED [REDACTED]		75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF DECEASED [REDACTED]	
77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF DECEASED [REDACTED]		79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF DECEASED [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF DECEASED [REDACTED]		83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF DECEASED [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF DECEASED [REDACTED]		87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF DECEASED [REDACTED]	
89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF DECEASED [REDACTED]		91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF DECEASED [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF DECEASED [REDACTED]		95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF DECEASED [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF DECEASED [REDACTED]		99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF DECEASED [REDACTED]	

BUREAU V. S.

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1724 CERTIFICATE OF DEATH

Reg. Dist. No.

01716

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>59</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1530 POPE AVE</u>		d. STREET ADDRESS <u>1530 POPE AVE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANK A SHIRMER</u>		4. DATE OF DEATH Month Day Year <u>FEB. 23 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 22 - 1896</u>
9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ROLLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>EASTERN ROLLER MFG</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTO.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AUGUST A SCHIRMER</u>		14. MOTHER'S MAIDEN NAME <u>MOLLIE BIEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>214-03-6051</u>	
17. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease (Patent foramen</u> <u>754.3</u> DUE TO <u>Ovale) with congestive failure.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>_____</u> DUE TO <u>_____</u> (c) <u>_____</u> INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 16</u> , 19 <u>52</u> , to <u>Feb. 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 21</u> , 19 <u>58</u> , and that death occurred at <u>4 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>413 Eastern Avenue</u> <u>Feb. 25, 1958</u> ACTUAL SIGNATURE <u>Harry B. Smith</u> M.D. PHYSICIAN'S NAME (Type) <u>Harry B. Smith, M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 27 '58</u>	
ADDRESS <u>418 Eastern Ave</u> <u>Balto., Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. A. R.</u>	

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01717

1725

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>6yr2mth25dys</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Riva, Maryland</b> <i>02x-2</i>	
f. STREET ADDRESS <b>Riva, Maryland</b>		• IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ellen</b>		4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 19, 1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Hugh McCusker</b>		14. MOTHER'S MAIDEN NAME <b>NeelyHoban</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Infarctive myocardial fibrosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic cardiovascular disease</b> (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Intertrochanteric fracture - left femur</b> <b>908.7</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>On 12-18-57 pt. slipped and fell to floor sustaining frac. left hip.</b>	
20c. TIME OF INJURY Month. Day. Year Hour <b>3:00</b> p. m. <b>12-18 1957</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Catonsville 28, Maryland</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Geo M. Kieffer</i>		DATE SIGNED <b>2-4-58</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-7-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St Mary's</b>	22d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Don G. Stuppig</i>		24a. REC'D BY REGISTRAR DATE <b>FEB 7 '58</b>	
ADDRESS <b>144</b>		24b. REGISTRAR'S SIGNATURE <i>W. Leach</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 3.

FEB 7 1938

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
NEW (11) DEPT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1726

## CERTIFICATE OF DEATH

01718

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>8 MO.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>911 MASEFIELD RD.</u>		d. STREET ADDRESS <u>1911 MASEFIELD RD.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>INEZ</u> Middle <u>M.</u> Last <u>SMITH</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>26</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 17, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS JARBOE</u>		14. MOTHER'S MAIDEN NAME <u>JANE STONE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>MRS. Celeste LANG</u> Address <u>911 MASEFIELD RD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November</u> , 19 <u>57</u> , to <u>2/26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/24</u> , 19 <u>58</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James Nolan</u> M.D.		DATE SIGNED <u>1 Mellow Hill Ave, East 29, Md.</u>	
PHYSICIAN'S NAME (Type) <u>NOLAN, JAMES J.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 1/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ST. MICHAELS CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>RIDGE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WITKE FUNERAL DIRECTORS, EDMONDSON</u> ADDRESS <u>4101 AVE</u>		24a. REC'D BY REGISTRAR <u>FEB 28 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Witke</u>			

CERTIFICATE OF DEATH

1. FULL NAME OF DECEASED <i>THOMAS HARRIS</i>		2. SEX <i>MALE</i>	
3. AGE <i>70</i>		4. DATE OF BIRTH <i>APR 10 1888</i>	
5. PLACE OF BIRTH <i>NEW YORK</i>		6. OCCUPATION <i>LABORER</i>	
7. MARITAL STATUS <i>MARRIED</i>		8. NAME OF SPOUSE <i>MARY HARRIS</i>	
9. PLACE OF DEATH <i>HOME</i>		10. CAUSE OF DEATH <i>HEART DISEASE</i>	
11. DATE OF DEATH <i>FEB 28 1959</i>		12. TIME OF DEATH <i>10:30 AM</i>	
13. SIGNATURE OF PHYSICIAN <i>DR. J. H. SMITH</i>		14. SIGNATURE OF REGISTRAR <i>JOHN D. JONES</i>	
15. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		16. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
17. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		18. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
19. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		20. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
21. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		22. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
23. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		24. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
25. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		26. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
27. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		28. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
29. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		30. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
31. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		32. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
33. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		34. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
35. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		36. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
37. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		38. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
39. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		40. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
41. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		42. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
43. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		44. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
45. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		46. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
47. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		48. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
49. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		50. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
51. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		52. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
53. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		54. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
55. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		56. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
57. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		58. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
59. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		60. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
61. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		62. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
63. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		64. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
65. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		66. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
67. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		68. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
69. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		70. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
71. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		72. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
73. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		74. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
75. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		76. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
77. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		78. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
79. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		80. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
81. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		82. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
83. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		84. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
85. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		86. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
87. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		88. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
89. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		90. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
91. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		92. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
93. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		94. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
95. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		96. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
97. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		98. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	
99. SIGNATURE OF DECEASED <i>THOMAS HARRIS</i>		100. SIGNATURE OF WITNESS <i>MARY HARRIS</i>	

RECEIVED  
FEB 28 1959  
BUREAU V. 8

## 1728 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <b>MARY AGNES SMYRK</b>				2. DATE OF DEATH <b>Feb. 13, 1958</b>	
3. PLACE OF DEATH: A. <b>Baltimore City, Maryland Catonsville</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b>	
B. FULL NAME OF (If not in hospital or institution, give street address or location) <b>House in the Pines 16 Fusting Ave.</b>				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>West Edmondale</b>	
c. Length of stay in Baltimore Yrs. <b>90</b> Mos. <b>16</b> Days <b>16</b>				D. STREET ADDRESS (If rural, give location) <b>5426 Addington Rd.</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>widowed</b>	8. DATE OF BIRTH <b>Apr. 16, 1869</b>	9. AGE (In years last birthday) <b>88</b>	10. Under 1 Year Months: Days: 11. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>Md.</b>			13. FATHER'S NAME <b>John Calvin McCahan</b>		
14. MOTHER'S MAIDEN NAME <b>Ellinor V. Johnson</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		
16. SOCIAL SECURITY NO. <b>none</b>			17. INFORMANT ADDRESS <b>Mrs. Ellinor Blocher - 5426 Addington Rd.</b>		
18. <b>334X</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Lobar Pneumonia</b> DUE TO (A)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Arteriosclerosis</b> DUE TO (B) <b>Cerebral degenerative changes</b> DUE TO (C)					
INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b> <b>4 yrs.</b> <b>3 yrs.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 13, 1958</b> to <b>Feb. 13, 1958</b> , that (I) (we) last saw the deceased alive on <b>Feb. 13, 1958</b> , and that death occurred at <b>4:20 P. M.</b> , from the causes and on the date stated above.					
23A. SIGNATURE <b>Dr. C. Wells</b>		23B. ADDRESS <b>4100 Edmondway Ave</b>		23C. DATE SIGNED <b>2/13/58</b>	
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>2/17/58</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		
DATE RECEIVED BY LOCAL REGISTRAR <b>FEB 27 1958</b>		REGISTRAR'S SIGNATURE <b>Wm. I. Lickner</b>		25. FUNERAL DIRECTOR ADDRESS <b>Wm. I. Lickner &amp; Sons, Balto.</b>	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER



BUREAU Y. S.

FEB 01 1948

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1729 CERTIFICATE OF DEATH

01721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>16 mos.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Wilhelmina</u> Middle <u>Stedding</u> Last <u>Stedding</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>19 58</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 14, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>78</u>
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hospital records</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Heart Disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a) <u>260X Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>No injury</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 4</u> , 19 <u>56</u> , to <u>Feb. 1</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb. 1</u> , 19 <u>58</u> , and that death occurred at <u>6:05 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radauskas</u> M.D.		DATE SIGNED <u>2/1/58</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		<u>Catonsville 28 Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Hines - Sons Rustictown Md.</u>		24a. REC'D BY REGISTRAR <u>Feb 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Quinn</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 4 1958

RECEIVED

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1556 CERTIFICATE OF DEATH

01722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arbutus</b>		c. LENGTH OF STAY IN 1b <b>6 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1012 St. Charles St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Adele</b> Middle <b>J.</b> Last <b>Storm</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>12</b> Year <b>1958.</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1906</b>
9. AGE (In years last birthday) <b>52 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Miller</b>		14. MOTHER'S MAIDEN NAME <b>Alice Bragg</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-28-5187</b>	
17. INFORMANT <b>Raymond L. Storm</b>		Address <b>1012 St. Charles Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1945</b> , 19____, to <b>Feb 12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 11</b> , 19 <b>58</b> , and that death occurred at <b>1 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Morris B. Schreiber</b>		ADDRESS (Street, city or town, state) <b>54 S. Fulton Ave.,</b> DATE SIGNED <b>12-14-58</b>	
PHYSICIAN'S NAME (Type) <b>Morris B. Schreiber</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-15-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Park</b>	22d. LOCATION (City, town, or county) (State) <b>Elkridge Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard Strong</b>		24a. REC'D BY REGISTRAR <b>FEB 18 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

181



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1730 CERTIFICATE OF DEATH

01723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mths5days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>William Lewis Stratton</b>		4. DATE OF DEATH Month <b>February</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 22, 1875</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>82</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Thomas J. Stratton</b>		14. MOTHER'S MAIDEN NAME <b>Molly Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 20</b> , 19 <b>58</b> , to <b>Feb. 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 21</b> , 19 <b>58</b> , and that death occurred at <b>10:30a</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stella Wachslar</b>		ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED <b>2-21-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>	
22a. BURIAL CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>2-22-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Home Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Freeland Ky</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Demarc &amp; Fink</b>		ADDRESS <b>Elk Runne Md</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Reed</b>	
DATE <b>FEB 25 '58</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 25 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1731 CERTIFICATE OF DEATH

Reg. Dist. No.

01724

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>221 Brightside</u>		d. STREET ADDRESS <u>221 Brightside</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George A Strauss</u>		4. DATE OF DEATH Month Day Year <u>February 17 1958</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 5-1892</u>
9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Bruiat</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iron Worker</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Strauss</u>		14. MOTHER'S MAIDEN NAME <u>Beulah Grace Strauss (Wife)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-09-8910</u>	
17. INFORMANT <u>Mother's Maiden Name</u>		Address <u>Mary Jones</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> DUE TO (c) <u>7 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Apr</u> , 19 <u>57</u> , to <u>17 Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>fall</u> , 19 <u>57</u> , and that death occurred on <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Paul H Royse</u> M.D. <u>808 Reisterstown Rd</u> <u>17 Feb 5-8</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Paul H Royse</u> <u>Pikesville 8</u> <u>md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>2-21-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAWN</u>	22d. LOCATION (City, town, or county) (State) <u>WOODLAWN, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Murrell, Pikesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. H. Search</u>

BUREAU V. S.

FEB 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1732 CERTIFICATE OF DEATH

01725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Balt o.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pikesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3509 Overbrook Rd.</b>				d. STREET ADDRESS <b>3509 Overbrook Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>SUMMERFIELD</b> Last <b>SUMMERFIELD</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>23,</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 22, 1880</b>	
9. AGE (In years last birthday) <b>78 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ferdinand Hechinger</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Winternitz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. A. Watner - 3509 Overbrook Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UREMIA</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1955</b> to <b>Feb 23, 1958</b> , that I last saw the deceased alive on <b>Feb 23, 1958</b> , and that death occurred at <b>11 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jerome J. Collier</b> M.D.				ADDRESS (Street, city or town, state) <b>2217 South Road</b>		DATE SIGNED <b>2-25-58</b>	
PHYSICIAN'S NAME (Type) <b>Jerome J. Collier, M. D.</b>				Baltimore 9, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oheb Shalom Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekner</b>				ADDRESS <b>444 S. Baltimore</b>		24a. REC'D BY REGISTRAR <b>FEB 27 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm. J. Tiekner</b>			



FEB 27 1958

RECEIVED  
FEB 27 1958

## 1733 CERTIFICATE OF DEATH

01726

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>4mths2ldys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Adreton</b> Last <b>Sweeney</b>		4. DATE OF DEATH Month <b>Febr.</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 5, 1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired fireman</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Walter Sweeney</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Stranley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records; SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arterio sclerosis.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 21c. TIME OF INJURY Month. Day. Year Hour a. m. 19 p. m. 21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 21f. (City or town) (County) (State) 21g. INTERVAL BETWEEN ONSET AND DEATH 21h. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21. I certify that I attended the deceased from <b>Jan. 22, 1958</b> , to <b>Febr 15, 1958</b> , that I last saw the deceased alive on <b>Febr 15, 1958</b> , and that death occurred at <b>8 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b> DATE SIGNED ACTUAL SIGNATURE <b>Isadore Turenk, M.D.</b> PHYSICIAN'S NAME (Type) <b>Catonsville 28, Md.</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-19-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dean Funeral Home</b>		ADDRESS <b>4812 Ga. Ave. Washington</b>	
24a. REC'D BY REGISTRAR <b>FEB 24 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. S.

FEB 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1734 CERTIFICATE OF DEATH

Reg. Dist. No.

03013

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>Balt.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>				c. LENGTH OF STAY IN 1b <b>2 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BEAU</b> Middle <b>C</b> Last <b>TALLEY</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>26</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 23, 1894</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PAPERHANGER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>DECORATING</b>		11. BIRTHPLACE (State or foreign country) <b>MOUNT SIDNEY, VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILFORD TALLEY</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA DODSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b> (If yes, give war or dates of service) <b>WW-1</b>				16. SOCIAL SECURITY NO. <b>212-18-8137</b>		17. INFORMANT <b>CLIN. REC. VET. ADM. HOSP. FORT HOWARD MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COR PULMONALE</b> <b>527.1</b> DUE TO <b>EMPHYSEMA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b> <b>UNKNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>FEBRUARY 24, 19 58</b> , to <b>FEBRUARY 26, 19 58</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, FORT HOWARD, MARYLAND</b> DATE SIGNED <b>2/27/58</b> ACTUAL SIGNATURE <b>Irving Freeman</b> M.D. PHYSICIAN'S NAME (Type) <b>IRVING FREEMAN, M.D., Chief, Medical Service, VAH, Fort Howard, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-3-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Road, Balto., Md.</b>				24a. REC'D BY REGISTRAR <b>W. J. Seduch</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Seduch</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled out, the funeral director, TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1735 CERTIFICATE OF DEATH

01727

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Overlea</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>15 Fuller Ave.</b>		d. STREET ADDRESS <b>15 Fuller Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lina</b> Middle <b>Tanner</b> Last <b>Tanner</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>28</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 2, 1868</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Barth</b>		14. MOTHER'S MAIDEN NAME <b>Unknown Baumgartner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ida Hedderick</b> Address <b>15 Fuller Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Chronic heart failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>chronic myocarditis</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH 3 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 13, 1958</b> to <b>Feb 28, 1958</b> , that I last saw the deceased alive on <b>Feb 26, 1958</b> , and that death occurred at <b>1 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>26 Feb 1958</b>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.			
PHYSICIAN'S NAME (Type) <b>[Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 3, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b> ADDRESS <b>7401 Belair Rd</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 5 '58</b>	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled, the funeral director, TO FUNERAL DIRECTOR: Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Race, Date of Birth, Date of Death, Cause of Death, and other medical details. The form is mostly blank with some faint markings.

*Carroll & Lee Lee & Lee  
Chesapeake Hypocrite*

**RECEIVED**  
MAR 5 1958  
BUREAU V. 3

*13 28-2*

*10-11-58  
L. Lee*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1736 CERTIFICATE OF DEATH

01728

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution) Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Robert R. Taylor State Training School</i>		d. STREET ADDRESS <i>10002 Raynor Rd. Plover Spring, Md.</i>	
3. NAME OF DECEASED (Type or print) <i>Gary Jay TEBELEFF</i>		4. DATE OF DEATH <i>February 17, 1958</i>	
5. SEX <i>M.</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/22/1947</i>
9. AGE (In years last birthday) <i>10</i> yrs. <i>11</i> Months <i>23</i> Days <i>10</i> Hours <i>10</i> Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Gilbert Tebeleff</i>		14. MOTHER'S MAIDEN NAME <i>Helen Schirley Lewis Tebeleff</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Gilbert TEBELEFF</i>		Address <i>10002 Raynor Rd. Plover Spring, Md.</i>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>per asphyxiation due to bilateral bronchopneumonia with pulmonary edema, giant hypertrophic, hypercapnic, peritonitis with intestinal tract</i> DUE TO (b) <i>peritonitis with intestinal tract</i> DUE TO (c) <i>Malnutrition, Starvation &amp; severe dehydration</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Malnutrition, Starvation &amp; severe dehydration</i>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Dr. Rich. Gindenberg (Pathologist)</i> M.D.		ADDRESS (Street, city or town, state) <i>700 Fleet Street Balto.</i> DATE SIGNED <i>2/19/58</i>	
PHYSICIAN'S NAME (Type) <i>Dr. Rich. Gindenberg (Pathologist)</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>2/20/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Orl Hill Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Orl Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Franky Russell</i> ADDRESS <i>4217 9th St</i>		24a. REC'D BY REGISTRAR <i>W. J. Smith</i> DATE <i>FEB 24 '58</i>	24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1958

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 1737 CERTIFICATE OF DEATH

01729

Item 3, Film G-226 2/28/58.cac

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u>		STATE <u>Md.</u>		COUNTY <u>Howard</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>10 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>BALTIMORE</u>		<u>3V01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PARADISE NURSING HOME</u>				STREET ADDRESS (If rural give location) <u>2013 WILHELM ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Arahanna E. THOMAS</u>				<b>4. DATE OF DEATH</b> (Month) <u>Feb.</u> (Day) <u>25</u> (Year) <u>1958</u>			
<b>5. SEX</b> <u>FEMALE</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>SINGLE</u>	<b>8. DATE OF BIRTH</b> <u>April 12, 1871</u>		<b>9. AGE last birthday</b> <u>86</u> yrs.	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SEAMSTRESS</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Clothing Mfg.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>GEORGE P. THOMAS</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>NAOMI SHIPLEY</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>216-03-2687</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Charles Lichtenberg 5035 Longwood</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.1 IMMEDIATE CAUSE (A)</b> <u>Chronic Congestive</u>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>ST.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Heart Failure</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Arterio Sclerotic Cardio-Vascular</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Disorder</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., and that death occurred at....., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>George L. Schaub</u>		<b>M.D.</b> <u>M.D.</u>		<b>ADDRESS (Street, city, town, state)</b> <u>1303 Frederick Rd. Catonsville, Md.</u>		<b>DATE SIGNED</b> <u>2/25/58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>2-28-58</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Good Shepherd</u>		<b>LOCATION (City, town, or county)</b> <u>Howard County, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>W. L. Smith</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>George L. Schaub 2101 Frederick Ave</u>			
<b>DATE</b> <u>FEB 28 '58</u>							



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RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01730

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Baltimore</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middle River</u>			c. LENGTH OF STAY IN 1b  		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Middle River</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  				d. STREET ADDRESS <u>950 Bengies Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>James Thomas</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>Feb 9 1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 15, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY  				11. BIRTHPLACE (State or foreign country) <u>Mecklenburg County, N.C.</u>		12. CITIZEN OF WHAT COUNTRY?  	
13. FATHER'S NAME <u>Madison Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Emiline ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  		16. SOCIAL SECURITY NO.  		17. INFORMANT <u>Howard Hawkins</u>		Address <u>944 Bengies Road</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> <u>420.1</u> DUE TO <u>Generalized Arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)  			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>SAACK C Collins</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type)  				DATE SIGNED <u>2-11-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/14/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundle County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Michael E. Elickson</u>				ADDRESS <u>29 N. CAROLINE ST</u>		24a. REC'D BY REGISTRAR <u>FEB 13 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>				 			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

FEB 13 1953

RECEIVED

RECEIVED  
FEB 13 1953  
BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1739

## CERTIFICATE OF DEATH

01731

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY IN 1b <u>9 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>College Manor</u>		d. STREET ADDRESS <u>5203 Falls Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Thomas</u> Last <u>Thomas</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 1, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>4</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Elkridge</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Davison Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Dobbin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Hospital Record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatic cardiac disease, mitral stenosis, insuff. aortic atherosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 1941, to Feb 2, 1958, that I last saw the deceased alive on Feb 2, 1958, and that death occurred at 10:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Milton Sherry</u>		ADDRESS (Street, city or town, state) <u>11 E. Chase St</u>	
PHYSICIAN'S NAME (Type) <u>Milton Sherry M.D.</u>		DATE SIGNED <u>2/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Feb 6, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Jenkins &amp; Sons Co.</u>		ADDRESS <u>4905 York Road</u>	
24a. REC'D BY REGISTRAR <u>FEB 7 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Beach</u>	

BUREAU V. S.

FEB 7 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01732

1740

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>				c. LENGTH OF STAY IN 1b <b>7 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HYATTSVILLE</b> 16152			
f. STREET ADDRESS <b>4602, EMERSON ST.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR RAY THOMPSON</b>				4. DATE OF DEATH Month Day Year <b>2 26 1958</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/1/91</b>	
9. AGE (In years last birthday) yrs. <b>67</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RAILROAD</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>OHIO</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOSEPH T. THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA KINER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY TUBERCULOSIS</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X DIABETES MELLITUS</b>				INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>7/19</b> , 19 <b>57</b> , to <b>2/25</b> , 19 <b>58</b> . That I last saw the deceased alive on <b>2/25</b> , 19 <b>58</b> , and that death occurred at <b>12:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Mt. Wilson, Maryland</b> DATE SIGNED ACTUAL SIGNATURE <b>William Newcomer</b> M.D. <b>Superintendent</b> PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. Gasch's Sons Hyattsville, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JOSEPH T. THOMPSON		2/15/50	
RACE		SEX	
WHITE	MALE	X	
AGE		DATE OF BIRTH	
51	2/1/1899	X	
PLACE OF BIRTH		CITY	
OHIO	DAYTON	X	
RESIDENCE		CITY	
1114 N. KILPATRICK ST.	DAYTON, OHIO	X	
CAUSE OF DEATH		MANNER OF DEATH	
CORONARY THROMBOSIS & MYOCARDIAL INFARCTION		NATURAL CAUSE	
X		X	
SIGNATURE OF PHYSICIAN		DATE	
J. BURKAU, M.D.		2/15/50	
FEB 28 1950		RECEIVED	



FEB 13 1968

RECEIVED

1742

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OWINGS MILLS</b>		c. LENGTH OF STAY IN 1b <b>54RS. 3mo.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ROSEWOOD STATE TRAINING SCHOOL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>PATRICIA ROVERN THOMPSON</b>		4. DATE OF DEATH Month Day Year <b>FEBRUARY 2 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 21, 1940</b>
9. AGE (In years last birthday) <b>17</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES HOBART THOMPSON</b>		14. MOTHER'S MAIDEN NAME <b>MARY LAVINIA M'CORMICK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT Address <b>ROSEWOOD RECORDS</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <b>Dehydration due to malnutrition</b> <b>752x</b> DUE TO Conditions, if any, which gave rise to immediate cause (o), stating the <u>underlying</u> cause lost. (b) <b>Idiocy and cerebral palsy due to congenital</b> DUE TO (c) <b>hydrocephaly</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>700 Fleet Street Bldg 2, 2/3/58</b>			
ACTUAL SIGNATURE <b>Rich. Lindenberg</b> M.D.		PHYSICIAN'S NAME (Type) <b>Rich. Lindenberg</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB 5/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WASH. NATH. CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>SEALAND PR 600 Co. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. Annapolis MD</b>		24a. REC'D BY REGISTRAR <b>DATE 2/11/58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. W. Chambers Co. Annapolis MD</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or attending physician's office for 30 days after the death. After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director, page 3, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

FILE NO.

Form with multiple fields for death certificate information, including name, age, sex, race, date of death, and cause of death. The fields are mostly empty or contain faint, illegible text.

BUREAU V. 21

FEB 6 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11, Film G225, 2/10/58

CERTIFICATE OF DEATH

Reg. Dist. No. 01735

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Halethorpe</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>51 Halethorpe</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5504 Carville Ave.</b>				d. STREET ADDRESS <b>5504 Carville Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>CORA</b> Middle <b>ISABEL</b> Last <b>TOWNSEND</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1958</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 25, 1876</b>	
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>William H. Lane</b>				14. MOTHER'S MAIDEN NAME <b>Johanna</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <b>Simmons Funeral Home - Washington, D. C.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1 Arteriosclerotic Cardio Vasc dis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Jan 3, 1958</b> to <b>Feb 5, 1958</b> , that I last saw the deceased alive on <b>Feb 1, 1958</b> and that death occurred at <b>4:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>PEARL PASS M.D.</b>				ADDRESS (Street, city or town, state) <b>4001 Wilson Ave 2-5-58</b>			
PHYSICIAN'S NAME (Type) <b>I EARL PASS</b>				DATE SIGNED <b>Boero 29 Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM. J. TICKNER &amp; SONS</b>				ADDRESS <b>Baltimore 17, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Boero</b>			

BUREAU A.

6 FEB

RECEIVED

1743 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SALISBURY</b>		d. STREET ADDRESS <b>1110 N DIVISION STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>E.</b> Last <b>TROMLEY</b>		4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>8</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 17, 1889</b>
9. AGE (In years lost birthday) <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Business Analyst</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>IMLAY CITY, MICHIGAN</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSIAH TROMLEY</b>		14. MOTHER'S MAIDEN NAME <b>EVALINA BURROWS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>578-14-4291</b>	
17. INFORMANT <b>CLIN REC VET ADM HOSP FT HOWARD MD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF COLON WITH GENERALIZED METASTASIS AND PERITONITIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>153.8</b> (c) <b>153.8</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>18 MONTHS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 28, 19 58</b> , to <b>February 8, 19 58</b> , and that death occurred at <b>10:00a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH FORT HOWARD MD</b> DATE SIGNED <b>2-8-58</b> ACTUAL SIGNATURE <b>Chien Wei Lan</b> M.D. <b>VAH FORT HOWARD MD</b> <b>2-8-58</b> PHYSICIAN'S NAME (Type) <b>CHIEN WEI LAN</b> MD <b>VAH FORT HOWARD MD</b> <b>2-8-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>2-10-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ALL HOLLOWES CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>SNOW HILL, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WM Cook-Blight</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 13 '58</b>	
ADDRESS <b>6009 Harford Rd</b>		24b. REGISTRAR'S SIGNATURE <b>Deborah</b>	

MEDICAL CERTIFICATION

2

50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1744

## CERTIFICATE OF DEATH

01737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY IN 1b <u>52 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Powers Ave</u>		d. STREET ADDRESS <u>Powers Ave</u>	
3. NAME OF DECEASED (Type or print) First — Middle Last <u>Milton</u> <u>McComas</u> <u>Tucker</u>		4. DATE OF DEATH Month Day Year <u>February</u> <u>21</u> <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>20 March 1905</u>
9. AGE (In years lost birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>	
11. BIRTHPLACE (State or foreign country) <u>Cockeysville Baltimore MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Francis Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Amelia Dorsey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-18-7033</u>	
17. INFORMANT Address <u>Same</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO <u>Cerebral arteriosclerosis (over 10 yrs)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/8</u> to <u>Feb</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>20 February</u> , 19 <u>58</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Walter T. Kees</u> M.D.		ADDRESS (Street, city or town, State) <u>Cockeysville MD</u> DATE SIGNED <u>2-21-58</u>	
PHYSICIAN'S NAME (Type) <u>Walter T. Kees</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/25/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BAZIL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>COCKEYSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLAND FUNERAL HOME-1631 DRUID HILL AVE</u> ADDRESS		24a. REC'D BY REGISTRAR DATE <u>FEB 24 58</u>	24b. REGISTRAR'S SIGNATURE <u>W. J. ...</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1958

RECEIVED

## 1745 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hillcrest Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Lida</u> Middle <u>H.</u> Last <u>Underwood</u>		4. DATE OF DEATH Month <u>February</u> Day <u>15</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
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13. FATHER'S NAME <u>Joshua L. Bull</u>	14. MOTHER'S MAIDEN NAME <u>Eliza Shank</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY NO. <u>                    </u>	17. INFORMANT Address <u>Mrs. Lida B. Thompson, Parkton, Md.</u>
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Cardio Vascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 Min</u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)

21. I certify that I attended the deceased from Feb 15, 1958, to Feb 15, 1958, that I last saw the deceased alive on Feb 15, 1958, and that death occurred at 3:22 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE <u>G. M. France</u>	M.D. <u>Parkton, Md.</u>	ADDRESS (Street, city or town, state)	DATE SIGNED <u>2/15/58</u>
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PHYSICIAN'S NAME (Type) <u>H. M. FRANCE</u>	<u>PARKTON, MD</u>
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22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/18/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>
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23. FUNERAL DIRECTOR'S SIGNATURE <u>Geoff. Hartenstein, New Freedom Pa.</u>	ADDRESS	24a. REC'D BY REGISTRAR <u>FEB 24 58</u>	24b. REGISTRAR'S SIGNATURE <u>                    </u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEB 24 1958

RECEIVED

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01739

Item 8, Film G-227471/58.cac.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bowley's Quarters</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>454 Burke Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>E.</b> Last <b>Vadala</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>16,</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1895</b> <b>March 17, 1894</b>	9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>6</b> Days <b>3</b>	IF UNDER 24 HRS. Hours <b>12</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>American Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Anthony Vadala</b>				14. MOTHER'S MAIDEN NAME <b>Roberta Hawkins</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Nora E. Vadala</b> Address <b>1333 Limit Ave.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <b>Somin</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ o. m. _____ p. m. _____ Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Jack C. Collins</b>				DATE SIGNED <b>2-18-58</b>			
EXAMINER'S NAME (Type) <b>JACK C. COLLINS</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 21, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>				24a. REC'D BY REGISTRAR <b>524b. REGISTRAR'S SIGNATURE</b> <b>DATE</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



BUREAU V. S.

RECEIVED

FEB 26 1953

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1747

## CERTIFICATE OF DEATH

Reg. Dist. No. 01740

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b> 3V01-4	
3. NAME OF DECEASED (Type or print) First Middle Last <b>IDA VIRGINIA VOGT</b>		4. DATE OF DEATH Month Day Year <b>FEB 2 1958</b>	
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-7-1869</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>JAMES HENRY LEMON</b>		14. MOTHER'S MAIDEN NAME <b>SARAH R. IRVIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Frank L. Smith, Jr.</b> Address <b>Cockeysville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio-Sclerotic Cardio</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <b>Vascular disease</b> DUE TO (c) <b>5 MONTHS</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-14</b> , 19 <b>57</b> , to <b>1-31</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-31</b> , 19 <b>58</b> , and that death occurred at <b>4:30 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walter J. Kees</b>		ADDRESS (Street, city or town, state) <b>Cockeysville, Md.</b> DATE SIGNED <b>2/2/58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-4-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>FEB 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Robert Smith</b>			



1748

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Spring Grove State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Millie</u> First <u>A</u> Middle <u>Wagner</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-1895</u> 9. AGE (In years lost birthday) <u>62</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Reading Pa.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>George Werner</u>	
14. MOTHER'S MAIDEN NAME <u>Mathilda Nye</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>	
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>George J. Wagner, 908 Martin St., Allentown</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of the aorta</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u>5 years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericardial tamponade</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 7, 1957</u> , to <u>Feb. 8, 1958</u> , that I last saw the deceased alive on <u>Feb. 8, 1958</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bruno Radawskas</u> M.D.		ADDRESS (Street, city or town, state) <u>Spring Grove St. Hosp. Catonsville, Md</u>	
PHYSICIAN'S NAME (Type) <u>BRUNO RADAUSKAS</u>		DATE SIGNED <u>2/8/1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Feb. 12-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Blvd. Balt. Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Connelly</u> ADDRESS <u>Essex - Md</u>		24a. REC'D BY REGISTRAR <u>—</u> DATE <u>FEB 11 '58</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 11 1959

BUREAU V. B.



# 1 1749 Item 2 FilmG225 2-25-58 et 1749 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01742

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>Baltimore</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TOWSON</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PRESBYTERIAN HOME OF MARYLAND</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 10</b> 3V01.4	
f. STREET ADDRESS <b># 2 Beechdale Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARIAN</b> Middle <b>D.</b> Last <b>WALLACE</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>11,</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/1882</b>
9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sales woman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Woodbury, N. J.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Edgar F. Dell</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Records of Presbyterian Home of Md. Towson, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 443 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive arteriosclerotic C.V. disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Carcinoma of breast with regional metastasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>5 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 11</b> , 19 <b>58</b> , to <b>Feb 11</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 11</b> , 19 <b>58</b> , and that death occurred at <b>1:30 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>LeRoy J. Venable Jr</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>5608 York Rd, Baltimore 12, Feb 13, 58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Green</b>	22d. LOCATION (City, town, or county) (State) <b>Woodbury, N. J.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 13 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR A PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BALTIMORE

II

Government of Great Britain  
 Department of Health  
 Circular Memorandum  
 2 Jan 1939

BUREAU V. 2

RECEIVED

FEB 18 1939

BALTIMORE, MD 1939

John A. McNeill & Sons, Inc. 1900 Eastern Bldg.

1750  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> <b>3 YOI-4</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>			c. LENGTH OF STAY IN lb <b>5yrlmth3dys</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Eugene Santemyr Walter</b>			4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 58</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1921</b>		9. AGE (In years last birthday) <b>36</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Boswell Santemyr Walter</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Elizabeth Knight</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-05-6291</b>		17. INFORMANT Address <b>Records: SPRING GROVE STATE HOSPITAL</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of rectum</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>July 15</b> , 19 <b>57</b> , to <b>Feb. 19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Feb. 19</b> , 19 <b>58</b> , and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Stella Wachslar</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>		DATE SIGNED <b>2-19-58</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachslar, M. D.</b>		<b>Catonsville 28, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/ 158</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Tabor Cem.</b>		22d. LOCATION (City, town, or county) <b>Harford Co., Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>My Secretary</b>		ADDRESS <b>1800 E. Ave Balt</b>		24a. REC'D BY REGISTRAR <b>FEB 21</b>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 100-1

MINOR BOND

BUREAU V. S.

FEB 24 1939

RECEIVED

1751

CERTIFICATE OF DEATH

01744

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2815 Linganore Avenue</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Barbara J. Walton</i>		4. DATE OF DEATH <i>February 11 19 58</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 8, 1892</i>
9. AGE (In years last birthday) <i>65</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Chicago</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Basch</i>		14. MOTHER'S MAIDEN NAME <i>Agnes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Oscar F. Walton, 2815 Linganore</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Dissecting aortic aneurysm</i> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/11/58</i> 9 <sup>PM</sup> to <i>2/11/58</i> 1 <sup>PM</sup> , that I last saw the deceased alive on <i>2/11/58</i> , 19 <i>58</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. A. Grott</i>		ADDRESS (Street, city or town, state) <i>8100 Harford Road #14</i>	
PHYSICIAN'S NAME (Type) <i>H. A. Grott, M.D.</i>		DATE SIGNED <i>2/12/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>2/14/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>		ADDRESS <i>5305 Harford Road #14</i>	
24a. REC'D BY REGISTRAR <i>FEB 13 '58</i>		24b. REGISTRAR'S SIGNATURE <i>W. Lee</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filled with the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



RECEIVED  
FEB 18 1953

FEB 10 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1752

## CERTIFICATE OF DEATH

Reg. Dist. No.

01745

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Timonium</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Timonium</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2122 Fair Lane</b>		d. STREET ADDRESS <b>2122 Fair Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>E.</b> Middle <b>Alice</b> Last <b>Ward</b>		4. DATE OF DEATH Feb. 18 1958 Day Month Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 9, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emely W. Sebold</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jordon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Ellen R. Creswell, Fair Lane, Tim.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>5 YRS.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 15, 1958</b> to <b>Feb. 18, 1958</b> , that I last saw the deceased alive on <b>Feb. 15, 1958</b> , and that death occurred at <b>3 A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Timonium, Md.</b> DATE SIGNED <b>Feb. 19, 1958</b>			
ACTUAL SIGNATURE <b>William A. Pillsbury</b>		M.D. <b>Timonium, Md.</b>	
PHYSICIAN'S NAME (Type) <b>William A. Pillsbury</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/21/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cherry Hill, Cecil, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook-Towson, Inc York Rd. Towson 4 Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 21 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>Paul Smith</b>			

# CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

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FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenoxm</u>	c. LENGTH OF STAY IN 1b <u>14 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Glenoxm</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenoxm Road</u>		d. STREET ADDRESS <u>Glenoxm Road</u>	
3. NAME OF DECEASED (Type or print) <u>Henry Herman Watchman</u>		4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 29, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PHARMACY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARY LAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>WM WATCHMAN</u>		14. MOTHER'S MAIDEN NAME <u>OILMAN.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-26-0608</u>	
17. INFORMANT <u>HENRY H. WATCHMAN JR. GLENARM, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>352 X Hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 day</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260 X Diabetes Mellitus</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> NAME (Type) <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Ay</u> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-27-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Oak-Tawson</u>		24a. REC'D BY REGISTRAR <u>Tawson 4-24</u>	
24b. REGISTRAR'S SIGNATURE <u>Bel Ay</u>		DATE <u>Feb 26 1958</u>	

**BUREAU Y. S.**  
FEB 26 1938  
**RECEIVED**

*[Faint, mostly illegible text and markings on the form, including what appears to be a signature and various administrative notations.]*



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1754

Item 4 Film G226 3-3-58 et

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE Md. b. COUNTY Baltimoreb. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
Catonsville

c. LENGTH OF STAY IN 1b

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  
52 Catonsvilled. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  
6 N. Maiden Choice Laned. STREET ADDRESS  
PARADISE AVEe. IS RESIDENCE ON A FARM?  
YES ☐ NO ☒3. NAME OF DECEASED  
(Type or print)

First Georgia A. Middle Watkins Last

## 4. DATE OF DEATH

Month Feb. Day 18 Year 19 58

## 5. SEX

Female

## 6. COLOR OR RACE

Col.

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

## 8. DATE OF BIRTH

Mar 8 1872

## 9. AGE (In years last birthday)

85 yrs.

## IF UNDER 1 YEAR

## IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
Home10b. KIND OF BUSINESS OR INDUSTRY  
Domestic11. BIRTHPLACE (State or foreign country)  
Ind12. CITIZEN OF WHAT COUNTRY?  
U. S. A.

## 13. FATHER'S NAME

Adam Fuller

## 14. MOTHER'S MAIDEN NAME

Elizabeth May

## 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT

Mr Earl Kidwell Humberman

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Acute Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

422.1

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

Cardiovascular Disease (Artero Sclerotic)

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

## 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour o. m. p. m.

19

20d. INJURY OCCURRED  
While at work ☐ Not while at work ☐

## 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

## 20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

## ACTUAL SIGNATURE

Geo. S. M. Kieffer

M.D.

CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

## EXAMINER'S NAME (Type)

Geo. S. M. Kieffer M. D.

ASSISTANT MEDICAL EXAMINER ☐DEPUTY MEDICAL EXAMINER ☒

## 22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## 22b. DATE THEREOF

2-24-58

## 22c. NAME OF CEMETERY OR CREMATORY

Mt Auburn Cem.

## 22d. LOCATION (City, town, or county)

Baltimore, Md.

(State)

## 23. FUNERAL DIRECTOR'S SIGNATURE

## ADDRESS

Mrs. Frances A. Hemsley 578 W. Biddle St

## 24a. REC'D BY REGISTRAR

DATE FEB 24 '58

## 24b. REGISTRAR'S SIGNATURE

W. H. Hensley

BURKAV V. S.

FEB 24 1958

RECEIVED

1755

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>BALTO</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b <b>5 YRS.</b> 54 <b>ESSEX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>813 MYRTH AVE</b>		d. STREET ADDRESS <b>1813 MYRTH AVE</b>	
3. NAME OF DECEASED (Type or print) First <b>HENRY</b> Middle <b>WICKMAN</b> Last <b>WICKMAN</b>		4. DATE OF DEATH Month <b>2</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/15/1904</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PIPE FITTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SHIP CONSTR.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY WICKMAN</b>		14. MOTHER'S MAIDEN NAME <b>MARY MALDEIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-2037</b>	
17. INFORMANT <b>DOROTHY BOBLITZ WICKMAN - SAME</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>1 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 1956</b> to <b>Feb 4 1958</b> that I last saw the deceased alive on <b>Feb. 3 1958</b> and that death occurred at <b>8:10 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert J. Lyden</b> M.D.		ADDRESS (Street, city or town, state) <b>815 Chestnut Ave Balt. 21, Md.</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT J. LYDEN</b>		DATE SIGNED <b>2/5/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/8/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>DAK LAWN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO. CO, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Frank Bradley, Hurdock 40.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>FEB 6 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Quel...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 17

File No. 100

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>		<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. COLOR</p>		<p>9. EDUCATION</p>		<p>10. RELIGION</p>		<p>11. PLACE OF DEATH</p>		<p>12. CAUSE OF DEATH</p>	
<p>13. DATE OF DEATH</p>		<p>14. TIME OF DEATH</p>		<p>15. PLACE OF DEATH</p>		<p>16. NAME OF PHYSICIAN</p>		<p>17. SIGNATURE OF PHYSICIAN</p>		<p>18. SIGNATURE OF REGISTRAR</p>	
<p>19. NAME OF FUNERAL HOME</p>		<p>20. ADDRESS OF FUNERAL HOME</p>		<p>21. CITY AND STATE OF FUNERAL HOME</p>		<p>22. NAME OF FUNERAL HOME</p>		<p>23. ADDRESS OF FUNERAL HOME</p>		<p>24. CITY AND STATE OF FUNERAL HOME</p>	

BUREAU V. 2

FEB 6 1958

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cossey</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Cossey</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>		d. STREET ADDRESS <u>914 Kutz Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Katherine</u> Middle <u>Miece</u> Last <u></u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 25 - 1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>5</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Brecker</u>		14. MOTHER'S MAIDEN NAME <u></u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT (Daughter) <u>Catherine Bauslein</u>		Address <u>Above</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Pulmonary edema</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary occlusion</u> DUE TO (c) <u>Atel. He dies</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>1 hr.</u> <u>1 yr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>2/21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/21</u> , 19 <u>58</u> , and that death occurred at <u>9:20</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>D. Platt</u>		ADDRESS (Street, city or town, state) <u>420 Eastern Ave. EREX. MD</u> DATE SIGNED <u>2/21/58</u>	
PHYSICIAN'S NAME (Type) <u>J. PLATT M.D.</u>		420 EASTERN AVE. EREX. MD <u>2/21/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-25-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Hill Catholic</u>	22d. LOCATION (City, town, or county) (State) <u>Buffalo, N. Y.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connolly</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u></u>		24b. REGISTRAR'S SIGNATURE <u></u>	
DATE <u>FEB 27 '58</u>		<u></u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

See back for

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. OCCUPATION</p> <p>7. MARITAL STATUS</p> <p>8. COLOR</p> <p>9. EDUCATION</p> <p>10. RELIGION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. TIME OF DEATH</p> <p>15. SIGNATURE OF PHYSICIAN</p> <p>16. SIGNATURE OF REGISTRAR</p> <p>17. SIGNATURE OF WITNESSES</p> <p>18. SIGNATURE OF DECEASED</p>		<p>19. NAME OF PHYSICIAN</p> <p>20. ADDRESS OF PHYSICIAN</p> <p>21. SIGNATURE OF PHYSICIAN</p> <p>22. NAME OF REGISTRAR</p> <p>23. ADDRESS OF REGISTRAR</p> <p>24. SIGNATURE OF REGISTRAR</p> <p>25. NAME OF WITNESSES</p> <p>26. ADDRESS OF WITNESSES</p> <p>27. SIGNATURE OF WITNESSES</p> <p>28. NAME OF DECEASED</p> <p>29. ADDRESS OF DECEASED</p> <p>30. SIGNATURE OF DECEASED</p>
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BUREAU V. S.

FEB 27 1939

RECEIVED

## CERTIFICATE OF DEATH

01750

Reg. Dist. No.

1757

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN 1b <b>8 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Road near Greenspring Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Belle</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1887</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>Hoffmanville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Hoover</b>		14. MOTHER'S MAIDEN NAME <b>Mary M. Hampshire</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-18-5218</b>	
17. INFORMANT <b>Lee H. Williams, Greenspring Ave.</b>		Address <b>Lutherville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Nephritis, Chronic Myocarditis, Hypertensive C-V Disease</b> 592x DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>none</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>11-30-57</b> , 19____, to <b>2-25-58</b> , 19____, that I last saw the deceased alive on <b>2-22-58</b> , 19____, and that death occurred at <b>8:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>2-25-58</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		ADDRESS (Street, city or town, state) <b>6 Hanover Rd. Reisterstown, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 28, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Burgess Funeral Home</b>		24a. REC'D BY REGISTRAR <b>2-27-58</b>	
ADDRESS <b>3631 Falls Road</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it must be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

852-03-13

BUREAU V. S.

8361

RECEIVED

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1758

01751

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3V01.4 ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Collingwood Avenue off 6700 Block Loch Raven Boulevard.</b>		d. STREET ADDRESS <b>509 Baker Street</b>	
3. NAME OF DECEASED (Type or print) First <b>DAVID</b> Middle <b>EDWARD</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 2, 1908</b>
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ys</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Bernice Williams</b>		Address <b>1013 Linden</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive and Arteriosclerotic Cardiovascular Disease.</b> 443X X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Paul F. Guerin</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Paul F. Guerin, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/26/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>3/2/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Ann Arundel County</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>17 HALSTEAD</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 '58</b>	
ADDRESS <b>918 Druid Hill Ave</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 7 1953

RECEIVED



1759

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>md</b> b. COUNTY <b>Balt</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Towson</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eudowood - Towson 4, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>WILMER</b> Last <b>WILMER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>1958</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/7/14</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Balto Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>MAX R. MEYER</b>		14. MOTHER'S MAIDEN NAME <b>Emma Herdel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-01-3875</b>	
17. INFORMANT <b>Personal History</b>		Address <b>Hospital Records, Eudowood Sanatorium</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary TBC</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 mo</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Dec 23, 1957</b> , to <b>Feb 7, 1958</b> , that I last saw the deceased alive on <b>Feb 6, 1958</b> , and that death occurred at <b>3:45 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____			
ACTUAL SIGNATURE <b>Milton B. Kress</b>		M.D. <b>Eudowood Sanatorium</b>	
PHYSICIAN'S NAME (Type) <b>Milton B. Kress, M.D.</b>		<b>Towson 4, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/10/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>moreland memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lassahn Funeral Home</b>		ADDRESS <b>2401 Balair Rd</b>	
24a. REC'D BY REGISTRAR <b>DATE FEB 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Beach</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 10 1958

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE, MD.  
FEB 10 1958

CERTIFICATE OF DEATH

NAME OF DECEASED: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE OF DECEASED: [REDACTED]  
SIGNATURE OF WITNESS: [REDACTED]  
SIGNATURE OF PHYSICIAN: [REDACTED]  
SIGNATURE OF CORONER: [REDACTED]  
SIGNATURE OF JUDGE: [REDACTED]  
SIGNATURE OF CLERK: [REDACTED]

## 1760 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baynesville</b>		c. LENGTH OF STAY IN TB <b>3 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8617 Oakleigh Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAY MARGARET WITTS</b>		4. DATE OF DEATH Month Day Year <b>Feb. 26. 1958</b> 19	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 30. 1898</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Jeremiah Hubbard</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Blank</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>213-20-4718</b>		17. INFORMANT Address <b>George P. Witts 8617 Oakleigh Rd. -14</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic C-V disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b> <b>5 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4. 10</b> , 19 <b>58</b> to <b>2. 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2. 4</b> , 19 <b>58</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Wm. H. Grenzer</b> M.D. <b>1520 E. 33rd St. Balt., Md. 4. 28. 58</b>			
ACTUAL SIGNATURE <b>Wm. H. Grenzer</b> PHYSICIAN'S NAME (Type) <b>WM. H. GRENZER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Pk. Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>HENRY SANDER &amp; SONS, INC. Baltimore Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. BROWN		AGE 35		SEX Male		RACE White	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan. 15, 1893		OCCUPATION Clerk		EDUCATION High School	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH Mar. 3, 1928		CAUSE OF DEATH Tuberculosis		MANNER OF DEATH Natural	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF FUNERAL HOME J. H. Smith & Co.		NAME OF BURIAL PLACE Greenwood Cemetery		NAME OF MINISTER Rev. J. H. Smith	
NAME OF NEXT OF KIN Mrs. J. H. Smith		NAME OF WITNESS J. H. Smith		NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith	

BUREAU V. 2

MAR 3 1928

RECEIVED

## 1558 CERTIFICATE OF DEATH

Item 4 FilmG225 2-19-58 et

Reg. Dist. No.....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MARYLAND</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ARBUTUS</u>	LENGTH OF STAY (in this place) <u>3 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>ARBUTUS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1225 STEVENS AVE.</u>		STREET ADDRESS (If rural give location) <u>1225 STEVENS AVE.</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Henry</u> (Middle) <u>John</u> (Last) <u>VIENGER, JR.</u>		(Month) <u>February</u> (Day) <u>9</u> (Year) <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 9, 1895</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY VIENGER</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE GIESE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>		16. SOCIAL SECURITY NO. <u>214-05-3112</u>	
(If Yes, give war or dates of service) <u>WORLD WAR I</u>		17. INFORMANT & ADDRESS <u>MARY VIENGER 1225 STEVENS AVE.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.1 IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			<u>DOA</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerotic C-V Disease</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Had been under care of another M.D.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>W. H. Federer</u>		ADDRESS (Street, city, town, state) <u>1305 Francis Ave.</u>	
DATE <u>FEB 13 '58</u>		DATE SIGNED <u>2/14/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		24. REC'D BY REGISTRAR <u>Feb. 12, 1958</u>	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schuch</u>	
		ADDRESS <u>2101 Frederick Ave.</u>	

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



ENCLOSURE

1

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

W. H. H. W.

DEPARTMENT OF HEALTH (JANUARY 1950)

STATE OF MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

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BUREAU V. S.

FEB 13 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01755

Reg. Dist. No.

1761

<b>1. PLACE OF DEATH</b> a. COUNTY <u>BALTO</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> <span style="float: right;">b. COUNTY <u>BALTO</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COLGATE</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X COLGATE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>532 SOUTHERN AVE</u>				d. STREET ADDRESS <u>532 SOUTHERN AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>HOWARD ED YOUNG SR</u>				<b>4. DATE OF DEATH</b> Month <u>FEB</u> Day <u>13</u> Year <u>1958</u>			
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JULY 26-1890</u>	<b>9. AGE</b> (In years last birthday) <u>67</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>SMITH CO.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>BALTO.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>  </u>	
<b>13. FATHER'S NAME</b> <u>HENRY YOUNG</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>UKN.</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes, give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-07-1195A</u>		<b>17. INFORMANT</b> <u>HARRIET YOUNG</u> Address <u>SAME AS ABOVE</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY Tbc</u> DUE TO <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>  </u>	
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>					
<b>20c. TIME OF INJURY</b> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>	Month, Day, Year <u>  </u> <u>  </u> 19 <u>  </u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town)</b> <u>  </u>	<b>(County)</b> <u>  </u>	<b>(State)</b> <u>  </u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>MB Davis</u> <span style="float: right;">M.D.</span>			<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>2/13/58</u>		
<b>EXAMINER'S NAME (Type)</b> <u>MB DAVIS</u> <span style="float: right;">M.D.</span>			<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>FEB. 17-1958</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>OAK LAWN</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTO.</u> <u>MD.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John D Connelly</u>			<b>ADDRESS</b> <u>Essex 21 - md.</u>		<b>24a. REC'D BY REGISTRAR</b> <u>  </u>		
<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>			<b>DATE</b> <u>FEB 24 '58</u>				

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for 7 days. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINERS CERTIFICATE OF DEATH

1101

COUNTY

CITY

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO TOWN

DATE OF ENTRY INTO VILLAGE

DATE OF ENTRY INTO HAMLET

DATE OF ENTRY INTO CENSUS

BUREAU Y. L.

FEB 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01756

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.2em;">Baltimore</span> <span style="float: right;">1762</span> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <span style="font-size: 1.2em;">Md.</span> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Reisterstown</span>		c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">in transit</span>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Reisterstown Rd.</span>		e. STREET ADDRESS <span style="font-size: 1.2em;">2507 Maryland Ave.</span>	
<b>3. NAME OF DECEASED</b> (Type or print) <span style="font-size: 1.2em;">John</span> First <span style="font-size: 1.2em;">E.</span> Middle <span style="font-size: 1.2em;">Zielney</span> Last		<b>4. DATE OF DEATH</b> Month <span style="font-size: 1.2em;">Feb.</span> Day <span style="font-size: 1.2em;">6</span> Year <span style="font-size: 1.2em;">1958</span>	
<b>5. SEX</b> <span style="font-size: 1.2em;">Male</span>	<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">May 5, 1894</span>
<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">63</span> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <span style="font-size: 1.2em;">3</span> Days <span style="font-size: 1.2em;">0</span> Hours <span style="font-size: 1.2em;">1</span> Min.	
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Laborer</span>		<b>12. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">New York</span>	
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Walter Zielney</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Margaret</span>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="font-size: 1.2em;">No</span>		<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">219-05-5308</span>	
<b>17. INFORMANT</b> Address <span style="font-size: 1.2em;">Mr. George Stuck 2507 Md. Ave. Balto. Md.</span>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <b>PART I. DEATH WAS CAUSED BY:</b>            IMMEDIATE CAUSE (a) <span style="font-size: 1.2em;">Fractured skull, Fractured rt. knee</span>            DUE TO <span style="font-size: 1.2em;">Fractured, dislocated rt. shoulder</span>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <span style="font-size: 1.2em;">Crushed pelvis, Compound fracture rt. ankle, Fractured L. ankle</span>            DUE TO <span style="font-size: 1.2em;">ankle, Fractured L. ankle</span>            (c)         </div> <div style="width: 15%; text-align: center;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">20 min.</span>  <span style="font-size: 1.2em;">20 min.</span>  <span style="font-size: 1.2em;">20 min.</span>  <span style="font-size: 1.2em;">20 min.</span> </div> </div>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <span style="font-size: 1.2em;">none</span>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">Pedestrian struck by automobile.</span>	
<b>20c. TIME OF INJURY</b> Hour <span style="font-size: 1.2em;">6:50</span> P.M. <span style="font-size: 1.2em;">Feb. 6</span> 19 <span style="font-size: 1.2em;">58</span>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Reist. Rd.</span>	<b>20f. (City or town)</b> (County) (State) <span style="font-size: 1.2em;">Reisterstown, Balto., Md.</span>
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.2em;">D. D. Caples</span>		<b>DATE SIGNED</b> <span style="font-size: 1.2em;">2-7-58</span>	
<b>EXAMINER'S NAME</b> (Type) <span style="font-size: 1.2em;">D. D. Caples, M. D.</span>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>	<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">Feb. 11, 58</span>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Finksburg Cemetery</span>	<b>22d. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Finksburg Md.</span>
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">J.F. Eline &amp; Sons</span>		<b>ADDRESS</b> <span style="font-size: 1.2em;">Reisterstown, Md.</span>	
<b>24a. REC'D BY REGISTRAR</b> DATE <span style="font-size: 1.2em;">FEB 11 '58</span>		<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">[Signature]</span>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be for the medical examiner. Give Page 5 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your use. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

BUREAU V. 21

1938-11-18